Jennifer Forrest, M.D.
Orthopedic Surgery

Mark Forrest, M.D.
Urology

Rivergate Orthopedics and Animas Urology, P.C.
555 Rivergate Lane, B1-106 | Durango, CO 81301
Ph: (970) 247-0508 | Fx: (970) 259-7091

Authorization to Use and/or Disclose My Health Information

Patient Name: _____ Date of birth: _____
Previous Name: _____

I. My Authorization

You may release the following records from the following medical office, hospital, or individual:
Name (or title) and organization: Rivergate Orthopedics and Animas Urology, P.C. and/or Durango Urological Associates, P.C
Address: 555 Rivergate Lane, B1-106
Phone: (970) 247-0508 Fax (970) 259-7091

You may use or disclose the following health care information:

- ☐ All my health information maintained by the above named practice
  (Circle below any information you want excluded)

Exclude: My health information related to drug abuse
Exclude: My health information related to alcohol abuse
Exclude: My health information related to HIV/AIDS/STD'S
Exclude: My health information related to psychological or psychiatric conditions, including psychotherapy notes

- ☐ My health information relating to the following treatment or condition: _____
- ☐ My health information for the date(s):_____
- ☐ Other: _____

You may disclose this health information to the following medical office, hospital, or individual:
Name (or title) and organization: _____
Address: _____
Phone: _____ Fax: _____
Reason(s) for this authorization (check all that apply):
☐ at my request ☐ other (specify)_____
This authorization ends: (date/event) _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:
• To take part in a research study, or
• To receive health care when the purpose is to create health information for a third party.
I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
• Fill out a revocation form. The form is available from the office, or
• Write a letter to the office.
Once the office discloses health information, the person or organization who receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)