Mark S. Dacey, M.D
425 S. Cherry St. Ste #907
Denver, CO 80246

ROCKY MOUNTAIN UVEITIS

Phone 720-826-6422
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PATIENT AUTHORIZATION TO REQUEST MEDICAL RECORDS

Patient to provide complete/accurate information, RMU will only process a valid/complete authorization form.

I. THE PATIENT. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: _____ Date of Birth: _____

II. AUTHORIZATION. I authorize _____ ("Authorized Party") to use or disclose the following: (check one)

☐ - All of my medical-related information.
☐ - My medical information ONLY related to: _____.
☐ - My medical-related information from _____, 20____ to _____, 20____.
☐ - Other: _____.

Sensitive records require specific patient authorization.

INITIAL THE APPROPRIATE RECORDS REQUESTED:

I authorize the information listed below to be disclosed: ***(initial below)***

____ Mental Health ____ STD'S (including HIV/AIDS) ____ Drug/ Alcohol Abuse

III. DISCLOSURE. The Authorized Party has my authorization to disclose Medical Records to:

Name: Rocky Mountain Uveitis, LLC / Mark S. Dacey, M.D.
Address: 425 S. Cherry St. #907 Denver, CO 80246
Phone: (720) 826 – 6422 Fax: (720) 826 - 6423
E-mail: scheduling@rmuveitis.com

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED: *(check one)*

____ Damage/Claim Evaluation and Presentation _____ At Request of the Individual

____ Other: Litigation

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization will automatically expire upon satisfaction of the need for disclosure or if revoked in writing by the patient, but in any event on (*date supplied by patient*) or days hereafter; or under the following conditions if they occur prior to the specific expiration date set forth above:

Patient Signature _____ **Date** _____

HIPAA Required Statement: I understand that non-research treatment may not be conditioned upon signing this release. I understand that the information provided under this release may be subject to redisclose by the receipt under circumstances no longer protected by HIPAA privacy rules. I understand that I may revoke this release at any time, except to the extent that action has already been taken to comply with it. To revoke this authorization, I must provide written notice to the doctor or health care provider named in the release and written notice to the organization or entity to whom I have authorized the release of information.