

Authorization to Use or Disclose My Health Information

Name of practice sending information: _____

Fax: _____ Telephone: _____

Name of practice accepting information: Le Celle Medical Wellness and Aesthetics

Kimberlee Terry, M.D.

1940 E. 18th Ave

Denver, CO 80206

(303) 781-2515

lecelle@gmail.com

Patient Name: _____ Date of Birth: _____

Information requested: _____

I understand I am not required to sign this authorization in order to get health care benefits. I must sign an authorization form to take part in any research study or to receive healthcare 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 practices 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 to fill out a revocation form or write a letter to the office. Once the office discloses health information, the person or organization that receives it may redisclose it and privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date

Printed Name