CRHH - CASTLE ROCK, CO
509 Wilcox St. Ste 200
Castle Rock, CO - 80104

# CRHH - HIPAA RELEASE FORM - UPDATED

## HIPAA RELEASE FORM

I hereby acknowledge that I am aware of the Privacy Practices (HIPPA) for Castle Rock Hormone Health and a copy is available for my records. In order for the Physician(s) and/or office staff to address privacy issues, please indicate with whom we may discuss your routine and/or emergent care and treatment.

Spouse (Optional): _____

Phone Number: _____

Family Member(s) (Optional): _____

Phone Number: _____

Guardian (Optional): _____

Phone Number: _____

Other: _____

When we call, may we leave a detailed phone message? * ☐ Yes ☐ No

Please select “NO” if you DO NOT want our physician or staff to discuss medical care and treatment with anyone other than other healthcare providers/representatives. * ☐ Yes ☐ No

Please Note: If there is any question in regard to diversion, abuse, or misuse of medications, as directed by Federal and State Laws, we must cooperate fully with Legal Authorities and regulatory Agencies.

**Patient or Representative Signature: ***

_____

Relationship to Representative: _____