

# **Blue Sky Neurology, LLC & Blue Sky Outpatient Neurology, LLC**

499 E Hampden Ave, Suite 360 Englewood, CO 80113 Phone (303) 781-4485 Fax (720) 274-0064

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## **Authorization to Disclose Information to Family Members/Friends**

I, the undersigned, authorize Blue Sky Neurosciences to disclose all of my medical information to the following people:

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I understand that I have the right to revoke or terminate this authorization by submitting a written revocation to the office manager for Blue Sky Neurosciences. I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is released. The privacy of this information may not be protected under federal privacy regulations.

## **HIPAA Message Authorization**

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check ALL that applies):

**Home Telephone**

- Okay to leave a message with detailed info  
 Leave a message with a call-back number only

**Cell Telephone**

- Okay to leave a message with detailed info  
 Leave a message with a call-back number only

**Work Telephone**

- Okay to leave a message with detailed info  
 Leave a message with a call-back number only

**Written Communication**

- Okay to mail to home address  
 Okay to mail to my work address  
 Okay to fax to this number:

Patient/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Name (Printed) \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_