ORTHOPAEDIC & SPINE CENTER OF THE ROCKIES

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

FAX COMPLETED FORM TO 970-493-0521 or email to ROI@orthohealth.com

FAX____ MAIL____ PICK UP____

1. I hereby authorize (name of provider) _____
to release the following information from the health records of:

Patient Name _____ Date of Birth _____

Address _____ Telephone _____

_____ S.S. # _____

- ❑ Limited to treatment dates or condition described below
  _____
- ❑ Therapy Notes
- ❑ Surgical report, history & physical
- ❑ Discharge summary
- ❑ Consultation reports
- ❑ Laboratory tests/EKG
- ❑ Imaging Reports
- ❑ Imaging on Disc
- ❑ Clinical office notes
- ❑ Payment records

Other (please specify) _____

2. I specifically authorize the release of information regarding the following condition(s):

- ❑ Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
- ❑ Psychological or psychiatric conditions
- ❑ Alcohol abuse
- ❑ Drug abuse

3. This information is to be released TO: _____
Physician's or Recipient's Name

_____
_____
Address (required)

Phone # _____ Fax # _____

Purpose of disclosure _____

4. This authorization is valid for one year from the date of signature unless otherwise stated.

I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I signthe authorization.

Signed: _____
(patient) (date)

_____
(or legal representative) (relationship to patient) (date)

_____
(signature of witness) (relationship to patient) (date)