ORTHOPAEDIC & SPINE CENTER OF THE ROCKIES

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

FAX TO RECIPIENT_____ MAIL TO RECIPIENT_____ SECURE EMAIL TO RECIPIENT_____ PICK UP_____

Fax Completed Form to 970-493-0521 (for Fort Collins, Loveland or Greeley Clinics)
Fax Completed Form to 303.772.9317 (for Longmont, Lafayette, Westminster Clinics)
OR Email to ROI@ORTHOHEALTH.COM

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

Patient Name _____ **Date of Birth** _____

Address_____**Telephone** _____

_____ **SS #** (last 4 only) _____

2. **Records to Be Released:**

☐ Clinical Office Notes	☐ Other (please specify)
☐ Imaging Reports	_____
☐ Radiology Images	
☐ Surgical Report, H&P, Discharge Summary	☐ Limited to Treatment Dates:
☐ Lab Results, EKG's	_____
☐ Consultation Reports	
☐ Therapy Notes	☐ Limited to Condition/Body Part:
☐ Payment Records	_____

3. I specifically authorize the release of information regarding the following condition(s):
☐ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)
☐ Psychological or Psychiatric Conditions
☐ Alcohol Abuse
☐ Drug Abuse

4. **This information is to be RELEASED TO:** _____
(Recipient Name)
Address_____ **PHONE #**_____
_____ **FAX #**_____
EMAIL _____

Purpose of Release: _____

5. **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 affect 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 sign the authorization.

6. _____ _____ _____
Signature of Patient or Legal Representative **Relationship, if Other than Patient** **Date**

_____ _____
Witness **Date**