ORTHOPAEDIC & SPINE CENTER OF THE ROCKIES
PATIENT REQUEST FOR ACCESS TO HEALTH INFORMATION
(FAX TO: 970-493-0521)

Patient Name: _____

I would like access to my health information in the following manner:

_____ Inspection of the health information as indicated below
_____ A copy of the health information indicated below
_____ Inspection and a copy of the health information indicated below

(Please check all that apply)

□ Limited to treatment dates for condition described below _____
□ X-ray written report
□ Surgical report, history & physical
□ Discharge summary
□ Consultation reports
□ Laboratory tests/EKG
□ X-ray copies (may be an additional charge)
□ Payment records
□ Other (please specify) _____

Information About Your Access Rights:

We will respond to your request for access within 30 days from the time we receive this completed form. In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your rights with regard to having the denial reviewed.

Charges for Access:

If you ask us to copy your health information, we will charge you $14.00 for the first 10 or fewer pages, $.50 per page for pages 11-40 and $0.33 per page thereafter. Copies of X-rays and similar tests will be charged at our cost.

Where to Submit this Form:

You must submit this form to Medical Records at Orthopaedic & Spine Center of the Rockies, 2500 East Prospect Road, Fort Collins, CO 80525. By submitting this form, I hereby request Orthopaedic Center of the Rockies to provide me the information indicated above.

Printed Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Signature: _____ Date: _____

For Use by Physician office:

Name of person receiving this form: _____ Date: _____

Date access provided: _____

For Inspection Completion:

Date of inspection by patient: _____ Patient Signature _____