OCR ORTHOPAEDIC & SPINE CENTER OF THE ROCKIES

FRONT RANGE ORTHOPEDICS & SPINE

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

(Mail ____ Pick Up____)

(FAX COMPLETED FORM TO: 970-493-0521)

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

Patient Name _____Date of Birth _____

Address _____Telephone _____

_____Social Sec. No. _____

- ❑ 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)
- ❑ 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 disclosed 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 and expires on _____ 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 sign the authorization.

Signed: _____
(patient) (date)

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

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