

Patient Information:	Name: _____ Maiden Name/Alias: _____ Date of Birth: _____ SSN# _____ Phone: _____ Medical Record# _____	
Health Information Released FROM: <input type="checkbox"/> Colorado Orthopaedics <input type="checkbox"/> Other: Person/Organization: _____ Street Address: _____ City/State/Zip Code: _____ FAX: _____ Phone: _____		Health Information Released TO: Person/Organization: _____ Street Address: _____ City/State/Zip Code: _____ FAX: _____ Phone: _____
Health Information to be RELEASED:	Date(s) of Treatment Received: _____ (If dates not specified, only the most recent year will be released) <input type="checkbox"/> Clinic Visits <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Labs <input type="checkbox"/> Radiology Images <input type="checkbox"/> Immunization <input type="checkbox"/> Other: _____ <div style="background-color: yellow; padding: 2px;"> <p>*Please note that all Operative Reports and MRIs must be requested from the hospital/facility where they were performed.*</p> </div> <p>All information regarding chemical dependency treatment, mental health and/or HIV or AIDS WILL BE RELEASED unless you tell us not to by initialing below:</p> <p>___ Do Not Release Chemical Dependency Treatment records ___ Do Not Release Mental Health records ___ Do Not Release HIV/AIDS records</p> <p>_____ By initialing here I give consent for Colorado Orthopaedics to verbally communicate with the listed authorized recipient.</p>	
Purpose of Release:	<input type="checkbox"/> Personal <input type="checkbox"/> Attorney <input type="checkbox"/> Continued Care - Appt Date: _____ <input type="checkbox"/> Insurance <input type="checkbox"/> Disability/ Social Security <input type="checkbox"/> Other: _____ <input type="checkbox"/> Transfer from Practice/Reason? _____ <div style="background-color: yellow; padding: 2px; text-align: center;"> <p>There may be a charge/fee for copies of records</p> </div>	
Delivery Method:	<input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> Pick up by patient/authorized designee (requires valid photo ID)	
Authorization/Revocation:	<p>This authorization will terminate in one year unless otherwise specified: _____.</p> <p>I understand that I may stop this release at any time by writing to Colorado Orthopaedic's Health Information Management department. Once the health information has been released to another facility or provider, there is no way to cancel or stop the release. I understand that when the health information is released the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that Colorado Orthopaedics will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form. I understand that I must sign this form to release my health information.</p> <p>X _____ X _____ Signature (If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.) Date</p> <p>_____</p> <p>Relationship to patient (if not patient)</p> <p>NOTE: An adult patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. Legal documentation of the right of access by the signing individual may be required.</p> <p style="text-align: center;"><i>A photocopy of this authorization is as valid as the original.</i></p>	
Staff Use Only:	Info Released By: _____ Date: _____ Form of ID: DL State ID Passport Other: _____	