ORTHOPEDIC CENTERS OF COLORADO

Phone: 866-506-7200
Fax: 720-798-6190

Authorization to Release Medical Records

Patient Name: ______________________________________ Date of Birth __ __/__ __/__ __ __ __

Address: ____

City: ______________________________ State: ____________ Zip: ____________

Phone: ____________________ Email: ______________________________________

By signing this document, I hereby request and authorize Orthopedic Centers of Colorado, LLC to release my medical records and/or x-ray studies to the below-named. I understand that release of this information will no longer guarantee the confidentiality of the information disclosed. I release Orthopedic Centers of Colorado, LLC and its physicians and staff from any and all liability concerning the disclosure of this information.

SPECIFIC RESTRICTIONS:

☐ Alcohol and/or Drug abuse, if any ☐ HIV / AIDS status, if any ☐ Psychological / Psychiatric Conditions, if any

INFORMATION REQUESTED:

☐ Office Visits ☐ Hospital Records ☐ Lab Reports ☐ X-Ray Images ☐ OP Reports ☐ Complete Chart

Other: ____

RELEASE INFORMATION TO:

Name: ____

Address: ____

City: ______________________________ State: ____________ Zip: ____________

Phone: _______________ Email: ______________________ Fax: _______________

I would like to receive the records by: ☐ Email ☐ Fax ☐ Mail ☐ Pick up in office ☐ Other ____________

1. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply. To revoke this authorization, I must provide written notice to Orthopedic Centers of Colorado.
2. I understand that this authorization will expire one year from the date given on this form.
3. I understand that if the information provided under this release is re-disclosed by the party listed above, Orthopedic Centers of Colorado is no longer able to protect that information under the HIPAA Privacy Rules.
4. I understand that unless I have otherwise notated above, this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse. By signing this form, I am specifically authorizing the release of this information unless specific restrictions are selected above.
5. I further agree to pay this facility the actual cost incurred for preparing a copy of my medical record if applicable.

____ ____________________

Signature of Patient or Parent/Legal Guardian Date