WESTERN ORTHOPAEDICS, P.C.

1830 FRANKLIN STREET, SUITE #450, DENVER, COLORADO 80218 ● PHONE: (303) 321-1333 ● FAX: (303) 321-0620

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996 WESTERN ORTHOPAEDICS, P.C. may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein.

Name: _____ Date: _____

SSN: _____ Date of Birth: _____ Phone: _____

I hereby request and authorize: _____

To release my personal health information to: **(name/address)**_____

(name/address)

(name/address)

I understand that the records to be released may include information pertaining to the following condition(s): Drug Abuse/Alcohol Abuse, Psychological or Psychiatric Conditions, HIV test results, or an AIDS diagnosis and/or an AIDS related condition, genetic testing, and sickle cell anemia/sickle cell disease.

Treatment Date(s): _____

Purpose of Release: _____

Information Requested (check what you authorize to be released):

☐ **Complete Chart**	☐ Physical Therapy Notes	☐ Psychological/Psychiatric Evaluations
☐ Physician's Notes	☐ Treatment Notes	☐ Billing
☐ Lab Reports	☐ Psychotherapy Notes	☐ Operative report
☐ Diagnostic Studies	☐ Office Notes	☐ Other: _____

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected by HIPAA.

I understand that I may revoke this authorization at any time by contacting Western Orthopaedics, P.C. at the above address, Attention: Medical Records Officer. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I certify that this request has been made voluntarily.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

I understand there may be fees associated with this request per Colorado regulations as follows: $14.00 for the first ten or fewer pages, $0.50 per page for pages 11-40, and $0.33 per page for every additional page.

I understand that this authorization will automatically expire 365 days from date of signature, or as follows: _____

_____ _____

Signature of Patient Date

_____ _____

Signature of Witness/Legal Guardian Date

If patient is unable to sign, please document reason below: