

# WESTERN ORTHOPAEDICS, P.C.

1601 EAST 19<sup>TH</sup> AVENUE, SUITE 6000, 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: \_\_\_\_\_

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.

Treatment Date(s): \_\_\_\_\_

Purpose of Release: \_\_\_\_\_

Information Requested (circle if to be released):

**Complete Chart**  
Physician's Notes  
Lab Reports  
Diagnostic Studies

Physical Therapy Notes  
Treatment Notes  
Psychotherapy Notes  
Office Notes

Psychological/Psychiatric Evaluations  
Billing  
Operative report  
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: