Canyon Orthopaedic Surgeons LTD
and Physical and Hand Therapy

M.S. MacCollum, M.D.
Orthopaedics & Arthroscopy

J.F. James Davidson, M.D.
Shoulder & Knee Disorders

David W. Sanders, M.D.
Orthopaedics, Arthroscopy, & Fractures

Curtis D. Miller, M.D.
Lower Extremity Reconstruction

Kent H. Chou, M.D.
Hand & Upper Extremity Disorders

Fellows or Members of the American Academy of Orthopaedic Surgeons

Authorization to Release Protected Health Information

I authorize the release of the following information from the health record of

Patient Identification: ______________________________ ______________
Patient Name Date of Birth

______________________________ ______________
Address Phone Number

Information Requested:

☐ HISTORY ☐ CONSULT ☐ LAB/X-RAY/EKG
☐ DISCHARGE SUMMARY ☐ OPERATIVE REPORTS ☐ OTHER:______________

Dates of Service From: ____________________ to __________________

Purpose: ☐ Self ☐ Continued Medical Care ☐ Attorney/Legal ☐ Patient Request ☐ Other: ________________

Information Released From:
____
Company, Person, Family
____
Address Zip Code

Information Sent To:
____
Company, Person, Facility
____
Address Zip Code

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes release of any such information.

I may refuse to sign this authorization form, I understand that Canyon Orthopaedic Surgeons will not discontinue or deny treatment based on my signing or not signing this authorization.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Canyon Orthopaedic Surgeons Notice of Privacy Practices explains this process in detail, which includes a request in writing. Unless I revoke this authorization earlier it will expire 6 (six) months from the date signed.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information.

I release Canyon Orthopaedic Surgeons, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized.

______________________________ ______________
Signature of Patient Date

______________________________ ______________
Signature of Legal Representative Relationship to Patient or Description of Authority to Act for Patient

For Healthcare Use Only

Date Received:______________ Date Sent:______________ Processor: ______________

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