ORTHOPEDIC CENTERS OF COLORADO

Authorization/Release of Protected Health Information (PHI)

***To ensure timely processing, please fill out authorization completely. Please allow up to 14 days for processing.**

PATIENT LEGAL NAME_____ **DATE OF BIRTH**_____
ADDRESS_____**PHONE**_____
CITY_____**STATE**_____**ZIP**_____

I hereby authorize the following facility to disclose Protected Health Information of the patient listed above.

Requested Delivery To:

Self: _____ Provider/Physician: _____ Legal: _____ Insurance: _____ Disability: _____ Other: _____

Delivery Method: Fax: _____ Email: _____ Mail/USPS: _____ Pick-up (Restrictions apply): _____

Email: _____

To: Name/Title: _____ Address: _____

City_____State_____Zip_____

Contact Phone:_____Fax: _____

Reason To Release PHI: _____

Type of Access Requested: **Specific Date Range: From**_____**To:**_____

Entire Record:_____ **Radiology CD:** _____**MRI Report:**_____ **Physician Orders:**_____**EMG:**_____

Progress Notes:_____ **Operative Report:**_____ **PT Notes:** _____ **Lab Report**: _____**Med List:** _____

Billing: _____ **Other:** _____

Expiration: This authorization shall expire upon: (check one): **Fulfillment of Request**_____ or **Date**: _____

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information. I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that there may be a fee involved with the fulfilment of this request. **See fee schedule below.** I understand that the term complete chart for release of Protected Health Information means that the only records generated by this facility will be released. I have read the above and authorize the disclosure of protected health information. For closed clinics there will always be a fee for copying records.

Signature of Patient/Legal Guardian_____**Date**_____

Fee Schedule

Fees for duplication of Protected Health Information complies with the regulations for Patient Medical Reproduction Fees 45 CFR 164.524 (C) (4) which states that patient shall pay for the reasonable cost of obtaining a copy of his/her patient record. The charge is $.39 per page for pages 1-40 and $6.50/flat fee for any additional pages over 40. Actual postage or shipping costs and applicable sales tax, if any, may be charged. The charge for an x-ray or medical records CD is $10.00 ea.