



Spine Colorado

1 Mercado Street, Suite 200, Durango, CO 81301

Patient ID:	Name: _____	Maiden Name/Alias: _____
	Date of Birth: _____	Phone: _____

Health Information Released FROM: <input type="checkbox"/> Spine Colorado <input type="checkbox"/> Other: Person/Organization: _____ Street Address: _____ City/State/Zip Code: _____ Fax: _____ Phone: _____	Health Information Released TO: <input type="checkbox"/> Spine Colorado <input type="checkbox"/> Other: Person/Organization: _____ Street Address: _____ City/State/Zip Code: _____ Fax: _____ Phone: _____
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Health Information to be RELEASED:	You may use or disclose the following health care information (check all that apply): <input type="checkbox"/> All my health information maintained by the above-named practice <input type="checkbox"/> My health information for the date(s): _____ <input type="checkbox"/> All images <input type="checkbox"/> My images from the date(s): _____ <input type="checkbox"/> Other: _____ All information regarding chemical dependency treatment, mental health and/or HIV or AIDS WILL BE RELEASED unless you tell us not to by initialing below: ___ Do Not Release Chemical Dependency Treatment records ___ Do Not Release Mental Health records ___ Do Not Release HIV/AIDS records
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Purpose of Release:	<input type="checkbox"/> Personal <input type="checkbox"/> Attorney <input type="checkbox"/> Continued Care - Appt Date: _____ <input type="checkbox"/> Insurance <input type="checkbox"/> Disability/ Social Security <input type="checkbox"/> Other: _____ <input type="checkbox"/> Transfer from Practice/Reason? _____ There may be a charge/fee for copies of records
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Delivery Method:	<input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> Pick up by patient/authorized designee (requires valid photo ID) <input type="checkbox"/> Email _____
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Authorization/Revocation:	<p>This authorization expires on: _____ or when the following event occurs: _____.</p> <p>If I fail to specify, this authorization will expire in 12 months from the signature date on this form.</p> <p>My Rights: I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility for benefits). However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health information for a third party.</p> <p>I may revoke this authorization in writing. If I revoke this authorization it would not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are to fill out a revocation form or write a letter to Spine Colorado at 1 Mercado Street, Suite 200, Durango, CO 81301.</p> <p>Once the office discloses health information, the person or organization that receives it may be able to redisclose it. Privacy laws may no longer protect it.</p> <p>X _____ X _____</p> <p>Signature (If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.) Date</p> <p>_____ Printed Name if signed on behalf of the patient Relationship to patient (if not patient)</p> <p>NOTE: An adult patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. Legal documentation of the right of access by the signing individual may be required.</p> <p><i>A photocopy of this authorization is as valid as the original.</i></p>
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