

Date of Request _____

Authorization to Release Personal Health Information

Patient Name: _____ Maiden Name: _____
 Date of Birth: _____ SSN: _____
 Home Phone #: _____ Work Phone #: _____

Information to be disclosed: (Please Check)

- Operative Report**
- Progress Notes**
- MRI (taken in Aspen office only)**
- X-ray Disc**
- Other**

The information to be disclosed is to cover the following periods of health care services or conditions related to:

Dates of Services: _____

You may disclose this information to:

Name and Organization: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Fax: _____

Please specify the purpose of your request:

- Medical Treatment
- Legal Reasons
- Insurance
- Changing Doctors/Moving
- Disability
- Other

This authorization for this release of health information will expire 1 year from the date requested.

We have the right to charge for additional copies: The cost is \$14.00 for the first 10 pages and 50¢ per pages 11-40 and 33¢ per page for pages 41 and up. We also have the right to charge for additional X-ray discs.

I understand that this authorization may include information concerning testing, diagnosis, or treatment of HIV, AIDS, or psychiatric or drug alcohol treatment that may be in my medical records.

I understand that if the person(s) or entity(ies) that receives this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Aspen Orthopaedic Associates, its employees, and its physicians from all liability arising from this disclosure of my health information.

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I must 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.

I may revoke this authorization in writing at any time. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may revoke this authorization via a written letter to the office.

A copy or fax of this authorization may be used with the same effectiveness as the original.

If someone other than the patient is picking up the requested health information, we require a written authorization from the patient naming the authorized individual. The authorized individual must present picture identification and sign for the medical records.

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of the patient

Relationship to patient