AUTHORIZATION TO USE OR DISCLOSE MY HEALTH INFORMATION

csog.net

Patient name: ____ Date of birth: ____

Previous name: ____

MY AUTHORIZATION

You may use or disclose the following health care information (check all that apply):

☐ My entire medical record maintained by Colorado Springs Orthopaedic Group

☐ My health information relating to the following treatment or condition ______________________________________

☐ My health information for the date(s): ____

You may disclose/request this health information to:

Full Name	Phone	Fax	Medical Records	RX pick up
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

Type of Records Requested (check all that apply):

☐ Complete Chart ☐ Imaging/Radiology Disk ☐ Imaging Reports ☐ Test/Lab Reports

☐ Office Notes ☐ Billing Records ☐ Surgery Notes

Reason(s) for this authorization (check all that apply):

☐ At my request ☐ Other (specify) ____

☐ Disability or FMLA Form

This authorization ends*:

*If no end date is provided, this authorization will expire one year from the date of signing.

☐ On (date): ________________________________

☐ When the following event occurs: ____

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 receive health care when the purpose is to create health information for a third party.

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:

- Fill out a revocation form. The form is available from the office;

  or

- Write a letter to the office.

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.

____

Patient or legally authorized individual signature　　Date　　Time

____

Printed name if signed on behalf of the patient　　Relationship (parent, legal guardian, personal representative, etc.)

STOP — For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Individual refused to sign ☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Communication barriers prohibited obtaining the acknowledgement ☐ Other ______________________________________

____

Colorado Springs Orthopaedic Group Employee Signature