WESTERN ORTHOPEDICS & SPORTS MEDICINE
Enhancing & Restoring Active Lifestyles

**Western Orthopedics and Sports Medicine**
**2373 G Road, Suite 100, Grand Junction, CO 81505**
**(970) 245-0484 phone (970) 242-3087 fax**

## AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

**Step 1** I hereby authorize Western Orthopedics & Sports Medicine to disclose or obtain information from the health records of:

Patient Name _____ Date of Birth _____ Telephone (w/ area code) _____

Patient Address , City, State, Zip _____

**Step 2** Covering the Date (s) of healthcare: From (mm/yyyy) _____ To (mm/yyyy) _____

**Step 3** **Please check all that apply (please see FEES FOR COPIES section below):** ***This will NOT be sent unless initialed***

| | | | |
|---|---|---|---|
| ○ Entire Chart | ○ MRI Report | ○ EKG Reports | ___ Drug Abuse Care |
| ○ Office Visits | ○ MRI Images | ○ Pathology Report | ___ Alcohol Abuse Care |
| ○ Operative Report | ○ X-ray Reports | ○ Physical Therapy Notes | ___ Mental Health Care |
| ○ History & Physical Exam | ○ X-ray Images | ○ Work Release | ___ HIV Testing Results |
| ○ Consultation | ○ Lab Reports | ○ Other _____ | |

**FEES FOR COPIES:** Federal and state laws permit and regulate fees charged for coping records. This facility has contracted with Bactes to make copies. You may be required to pre-pay for the copies. The charge is **$14 for the first 10 pages, $.50 for pages 11-39, $.33 for pages 40 and higher and a $10 charge for copying radiology images** performed at WOSM. The Colorado Board of Medical Examiners policy 40-7 states that **30 days** is "reasonable notice" when medical records have been requested. When records are requested in response to a patient's exercise of the right to review their medical records under Health Insurance Portability and Accountability Act (HIPAA), guidelines suggest **a response within 30 days** of a written request.

**Step 4** **For the purpose of**: ○ Personal Records ○ Transferring Care ○ Legal ○ Other _____

**Step 5** I would like this information to be **Obtained From**: I would like this information to be **Disclosed To**:

| | |
|---|---|
| Western Orthopedics and Sports Medicine<br>Name of Organization/Person | _____<br>Name of Organization/Person |
| 2373 G Road, Suite 100<br>Address | _____<br>Address |
| Grand Junction, CO, 81505<br>City, State, Zip | _____<br>City, State, Zip |
| 970-245-0484<br>Telephone Number | _____<br>Telephone Number |

**Step 6** I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date *(release will expire in one year unless otherwise indicated)*. Expiration Date___/_____/_____. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. *Note:* Information may no longer remain private.

**Step 7** Signature of Patient **or** Legal Representative _____ Date _____

If signed by legal representative:

**Step 8** Relationship to Patient _____ Signature of Witness _____

***Office use only: Received by:*** _____ ***Date:*** _____ ***Prepared by:*** _____ ***Date:*** _____

**Records Mailed:** ___ **Faxed:** ___ **Picked up:** ___ **Date:** _____ **Initials:** _____