Western Orthopedics & Sports Medicine
Enhancing & Restoring Active Lifestyles

Western Orthopedics and Sports Medicine
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(970) 245-0484 phone (970) 242-3087 fax

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

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

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

Please check all that apply:

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

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

_____ _____
Name of Organization/Person Name of Organization/Person

_____ _____
Address Address

_____ _____
City, State, Zip City, State, Zip

_____ _____
Telephone Number Telephone Number

For the purpose of: ○ Personal Records ○ Transferring Care ○ Legal ○ 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 ten or fewer pages, $0.50 per page for 11-40, $0.33 per page for addition and a $10 charge for copying radiology images.
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.

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

If signed by legal representative:

_____ _____
Relationship to patient Signature of Witness

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

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