Name: _____

Date of Birth: _____

SPINE COLORADO

1 Mercado Street Suite 200 Durango, Colorado 81301 Phone: 970-382-9500 Fax: 970-375-0007

Authorization to Use or Disclose Protected Health Information

Date: _____

Previous Name: _____

I. Authorization

I authorize the use or disclosure of the above-named individual's health information as described below (check all that apply):

☐ Office notes from _____ to _____ or for this treatment or condition: _____

(Circle "Include" or "Exclude" for each of the following)

Include or Exclude: My health information related to drug abuse

Include or Exclude: My health information related to alcohol abuse

Include or Exclude: My health information related to HIV/AIDS

Include or Exclude: My health information related to psychological or psychiatric conditions, including psychotherapy notes

☐ Xrays for this date(s) _____ or this body part _____

☐ MRIs for this date(s) _____ or this body part _____

☐ Records from other parties or facilities ☐ Electronic Copy of health information

(This is a Web Document Containing only diagnoses, medication, medication allergies)

☐ The entire medical record including Xray and MRI studies

☐ Other _____

This health information may be given to and used by the following individual or organization:

Name (or title) and organization: _____

Address: _____ City: _____ State: _____ Zip: _____

Disclosure method: ☐ **Pickup** (name of party_____) ☐ **Mail** ☐ **Email** (email address: _____)

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

☐ At my request

☐ Other (specify)

_____

_____

☐ Check here only when Durango Orthopedics/Spine Colorado requests the authorization for marketing purposes

☐ Check here only when Durango Orthopedics/Spine Colorado will get something of value for providing health information for marketing purposes

This authorization ends:

☐ On (date): _____, or

☐ When the following event occurs: _____

If I fail to specify an expiration date or event this authorization will expire in six months.

II. My Rights

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

- To take part in a research study.
- 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 do, I understand that this revocation does not apply to information that has already been released in response to 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. This form is available from this office.
- Write a letter to the attention of Durango Orthopedics' Privacy Officer.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

I understand that there may be a charge for medical record, xray, and/or MRI copies.

_____ _____ _____

Patient or legally authorized individual signature | Time

_____ _____

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