Spine Colorado

1 Mercado Street, Suite 200, Durango, CO 81301

Patient ID:	Name:_____ Maiden Name/Alias:_____ Date of Birth:_____ Phone: _____

Health Information Released **FROM**:	Health Information Released **TO:**
□ Spine Colorado □ Other: Person/Organization: _____ Street Address: _____ City/State/Zip Code: _____ Fax:_____ Phone:_____	□ Spine Colorado □ Other: Person/Organization: _____ Street Address: _____ City/State/Zip Code: _____ Fax: _____ Phone: _____

Health Information to be **RELEASED**:	**You may use or disclose the following health care information (check all that apply):** □ All my health information maintained by the above-named practice □ My health information for the date(s): _____ □ All images □ My images from the date(s): _____ □ Other:_____ **All information regarding chemical dependency treatment, mental health and/or HIV or AIDS WILL BE RELEASED unless you tell us not to by initialing below:** ____ **Do Not Release** Chemical Dependency Treatment records ____ **Do Not Release** Mental Health records ____ **Do Not Release** HIV/AIDS records
Purpose of Release:	□ Personal □ Attorney □ **Continued Care - Appt Date**: _____ □ Insurance □ Disability/ Social Security □ Other: _____ □ Transfer from Practice/Reason? _____ **There may be a charge/fee for copies of records**
Delivery Method:	□ **Mail** □ **Fax** □ **Pick up by patient/authorized designee (requires valid photo ID)** □ **Email** _____
Authorization/ Revocation:	This authorization expires on: _____ or when the following event occurs: _____. If I fail to specify, this authorization will expire in 12 months from the signature date on this form. 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 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. 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 to fill out a revocation form or write a letter to Spine Colorado at 1 Mercado Street, Suite 200, Durango, CO 81301. 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. X_____ X_____ **Signature** (If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.) **Date** _____ X_____ Printed Name if signed on behalf of the patient Relationship to patient (if not patient) **NOTE:** An adult patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. Legal documentation of the right of access by the signing individual may be required. *A photocopy of this authorization is as valid as the original.*