Colorado Springs Orthopaedic Group

AUDUBON ORTHOTIC & PROSTHETIC SERVICES

Authorization for Release of Records

Patient's Last Name: _____ First: _____ MI: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

I hereby authorize the following facility to disclose protected health information of the patient listed above.

From:	**To:**
Name/Title:	**Name/Title:**
Address:	**Address:**
Phone:	**Phone:**
Fax:	**Fax:**

Reason to release Protected Health Information (PHI): _____

Specific date range requested: _____ through _____, or All Dates ☐

Type of records or films requested (check all that apply):

☐ Complete Chart ☐ Imaging/Radiology-Films/CDs ☐ Billing Records ☐ Surgery Reports
☐ Office Notes ☐ Imaging Reports ☐ Test/lab Reports

I acknowledge and herby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results, or AIDS information. I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it. The information used of disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the term, Complete Chart for release of Protected Health Information (PHI) means that only records generated by this facility will be released. I have read the above and authorize the disclosure of the PHI.

Expiration Date: This authorization shall expire upon one year from the date signed.

Patient/Guardian Signature: _____ Date: _____