Northern Colorado Orthopedic Associates

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970-224-9890 (office) 970-224-9800 (fax)

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: _____ Date: _____

Date of Birth: ____/_____/____ Phone: _____ Email: _____

As Required by Health Insurance Portability and Accountability Act of 1996 NCOA may not use or disclose your health information except as provided in our Notice of Privacy Practices without your permission. Your signature on this form indicates that you are giving permission for the use and disclosure of protected health information described herein.

I hereby request and authorize NCOA to release my health information to:

Name: _____

Address: _____

Phone: _____ Fax: _____

Email: _____ Treatment Dates: _____

Purpose of Release: _____

Information Requested: □ Office Notes □ Operative Reports □ Lab Reports □ MRI Reports

□ X-RAY □ Bone Density □ Other _____

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected by HIPAA.

I understand that I may revoke this authorization at any time by contacting NCOA at the above address, Attention: Medical Records. I further understand that any revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I certify this request has been made voluntarily.

I understand I have a right to inspect and obtain a copy of any information disclosed pursuant to this authorization.

I understand there may be fees associated with this request per Colorado regulations as follows: No charge for 2018 records, $0.50 per page for all other records. There is a $1.00 charge on all X-Ray disc.

I understand that this authorization will automatically expire 365 days from date of signature, or as follows: _____

_____ _____
Signature of patient Date

_____ _____
Signature of Parent / Legal Guardian Date

_____ _____
Signature of Witness Date