Northern Colorado Orthopedic Associates

PO Box 327
Windsor, CO 80550

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: _____

Purpose of Release: _____

Information Requested: □ Office Notes □ 2017 □ 2018 □ other _____

□ X-ray Disc □ Operative Reports □ Bone Density

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.

Medical Record copying fees are established by the Colorado Department of Health which states the following fees:
$18.53 for the first ten (10) pages
$0.85 per page for pages 11-40
$0.57 per page for every additional page
$5.00 charge for x-ray disc

I understand that this authorization will automatically expire 365 days from date of signature.

_____ _____
Signature of patient Date

_____ _____
Signature of Parent / Legal Guardian Date