North Colorado Spine & Orthopaedics
6200 W 9th Street
Greeley, CO 80634

Consent to Access or Release Medical Records

_____ _____
Name of Patient (please print) Date of Birth

____ I request that _____ send ALL my medical records to the location listed below:

____I request that _____send the following information to the location listed below:
- Health information related to treatment of the following condition: _____
- Health information for the following date(s):_____
- Other: _____

(Circle the following as applicable):

Include / Exclude: My health information related to drug abuse
Include / Exclude: My health information related to HIV/AIDS
Include / Exclude: My health information related to alcohol abuse
Include / Exclude: My health information related to psychological or psychiatric conditions

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____ I request that North Colorado Spine & Orthopaedics send my records to the following location:

Name: _____
Address: _____
City: _____ State: _____
Phone Number: _____ Fax: _____

If you wish to pick up your medical records, please complete the following:

____ I request to inspect and/or receive copies of my medical records. I understand that the following charges apply: $14 for the first ten (10) or fewer pages of copies; $0.50 for each page from 11-40; and $0.33 for each page thereafter. (Refer to the Colorado Department of Health Regulation Chapter 2, part 5.2.3.4)

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, or
- To receive healthcare when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
- Write a letter to the office, or
- Sign here to **revoke**/Authorization: _____

Patient or legally authorized individual signature Date

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

_____ **X** _____ **X** _____
Patient or legally authorized individual signature **Date** **Time**

_____ _____
Printed name if signed on behalf of patient Relationship (Parent, legal guardian, etc.)