OCC CORNERSTONE ORTHOPEDICS AND SPORTS MEDICINE
3 Superior Drive, Suite 225 Superior, CO 80027 Phone: 303-665-2603 Fax: 303-420-2279

Patient Authorization for Release of Health Records to External Parties

Please be advised we have 30 days to complete delivery of all Medical Records requests, however, we will do our best to accommodate urgent deadlines. If pick up option is selected, Medical Records will call when records are ready.

❁ I authorize Cornerstone Orthopedics to disclose information form the health records of

Patient:______________________________ Date of Birth:______________________

To: Self______ or the following recipient:______________________________

Address:______________________________ City, State, Zip:______________________

Phone:____________________Fax:__________________Email:____________________

I would like my records ☐ Faxed ☐ Mailed ☐ Sent Secure Email (records will only be delivered by 1 method)

Please note Imaging/Records CD's can ONLY be mailed or picked up.

OR: I will pick up my records at ☐ St. Anthony North 144th ☐ Golden Office ☐ Superior Office

If mailed or pick up, I would like records ☐ on a CD or ☐ Printed

Information to be released

Entire Health Records (this includes everything in my chart, including records received from outside sources)

☐ I would like my Entire Health Records (beginning of chart to the present) ☐ Include imaging CD

☐ I would I like my Entire Health Records for the dates of__________ to __________ ☐ Include imaging CD

OR I would like only the specified records from my chart which I have checked below, for the specific dates of__________________ through__________________.

☐ Office Visit Notes ☐ Physical Therapy Reports ☐ Operative/surgical Reports ☐ Laboratory Results

☐ Photographs ☐ Imaging CD ☐ Radiology Reports ☐ Billing Records ☐ Other__________________

I give specific authorization to disclose the following information if applicable:

☐ Documentation of Aids diagnosis ☐ Drug & alcohol abuse treatment records ☐ HIV test results

☐ Psychiatric/Mental Health treatment records.

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by the authorization. However any disclosures already made with my permission are unable to be taken back. **I may revoke this authorization at any time by notifying Cornerstone Orthopedics in writing.** My treatment will not be based on the completion of this authorization form. If the information to be released by this authorization is re-released by the person or organization that receives it, the information may no longer be protected by Federal or Colorado privacy regulations.

Unless revoked earlier, this authorization is valid for one year unless otherwise specified here:__________. I release the individual or organization names in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be proved a copy of this signed authorization if requested. A photocopy of this authorization is as valid as the original.

______________________________ ______________________
Signature of Patient or Patient Representative Date

______________________________ ______________________
Printed name of Patient or Patient Representative Relationship to Patient