

Authorization For Use or Disclosure of Medical Record Information

Medical Record #



Orthopaedics
OF STEAMBOAT SPRINGS

Patient Information

Patient Full Name: _____ Date of Birth: _____
 Patient Address: _____ Home Phone: _____
 City: _____ State _____ Zip: _____ Work Phone: _____

Release Information To

I hereby authorize *Orthopaedics of Steamboat Springs* to release my medical records to:

- Mail Copies To (address below) Hold for Patient Pick-up Discuss Medical Record Information With (address below)

Name/Facility: _____ Attention: _____
 Address: _____ Phone: _____
 City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: * Personal Continuing Care * Legal * Insurance * Other _____

***COPY FEE:** We reserve the right to charge a reasonable fee for the cost of producing and mailing the copies. Base fee of 20.00 per chart. Please make checks payable to Bactes. Charts will be copied once payment is received.

Information to be Released

PLEASE BE SPECIFIC - include dates of treatment & provider name if applicable.

_____ Date(s) of Treatment _____
 _____ Date(s) of Treatment _____
 _____ Date(s) of Treatment _____

Authorization for Release of Statutorily Protected Information

DO NOT Leave This Section Blank - The requested medical record MAY or MAY NOT contain information that is statutorily protected. You must check either "Yes" or "No" and initial each category for Mt View Medical Group to properly process your medical record request.

Release Records? Check one				
	Yes	or	No	
Mental Health	<input type="checkbox"/>	or	<input type="checkbox"/>	Initial Here: _____
HIV Tests & Related Information	<input type="checkbox"/>	or	<input type="checkbox"/>	Initial Here: _____
Alcohol and/or Substance Abuse	<input type="checkbox"/>	or	<input type="checkbox"/>	Initial Here: _____



Please confirm that you have checked "Yes" or "No" and initialed all 3 protected information categories above even if they do not necessarily apply to the patient's records. If information is not released and/or form is incomplete, MVMG may be unable to fulfill this request.

Sensitive Information

Please check or indicate below any sensitive information that you **DO NOT** want released.

- Abortion Sexually Transmitted Disease AIDS/ARC
 Genetic Domestic Sexual Assault Other(s) _____

Patient's Signature

Date*

Know Your Privacy Right
refer to the HIPAA
"PRIVACY NOTICE"

Parent/Legally Recognized Representative Signature/Relationship To Patient**

Date*

*This Authorization is valid for 90 days (30 days for alcohol/drug abuse treatment) unless you specify other wise: _____. You may revoke this Authorization at any time by providing a written statement to the MVMG clinic where the Authorization was originally submitted, except to the extent that MVMG has already completed action on it.

** By my signature, I attest that I am the legally recognized representative of the above mentioned patient in accordance with the following: _____
 The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. MVMG will not condition treatment or payment of the provision of this Authorization. Patient does have a right to receive a copy of this form