Colorado Center for Arthritis & Osteoporosis, LLC

Authorization for Release of Medical Information – Initiated by Patient

Patient name: _____ **Date of Birth:** ___/___/_____

I authorize Colorado Center for Arthritis and Osteoporosis (CCAO) to use or disclose the following protected health information:

FROM:

Colorado Center for Arthritis & Osteoporosis

1715 Iron Horse Drive Longmont, St #100 CO, 80501

Fax: 720-494-4706 Phone: 720-494-4700.

TO:

_____

_____

_____

_____

Information to be disclosed:

- ☐ Entire medical record
- ☐ Labs
- ☐ Imaging
- ☐ Other: _____

Dates to be Disclosed:

- ☐ Last 12 months

Other: _____

Purpose of Disclosure (Choose ONE):

- ☐ Copy for patient
- ☐ Copy for Other Doctor
- ☐ Transfer patient care to other doctor
- ☐ Legal
- ☐ Other: _____

Form of Delivery (Please Check One) -

<u>For Personal Use ONLY</u>:

- ☐ Secure E-mail

  E-mail address: _____

Word: _____*(case sensitive)*

(Any word can be entered, it will be used as a password
To open the confidential HIPPA compliant email.)

<u>For Personal & Other Use</u>:

- ☐ Fax
- ☐ Paper copy – ☐ mailed
  ☐ Pick up by patient
- ☐ CD – ☐ mailed
  ☐ Pick up by patient

Redisclosure of Health Information:

I understand that the parties disclosing and receiving this health information may not redisclose it without obtaining another authorization from me, unless the disclosure is specifically required or permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized Redisclosure and the information may not be protected by federal confidentiality rules.

Patient Rights: I understand that:

- I can see and copy the health information described above and that I will receive a copy of this authorization form after I sign it.
- I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.
- I can revoke this authorization by writing to CCAO at any time, but my revocation will not apply to the information that has already been disclosed or used in response to this authorization.

Expiration of Authorization: Unless revoked, this authorization will remain active indefinitely.

I have reviewed and understand this authorization to Disclose Protected Health Information. I affirm that it accurately reflects my wishes.

_____ _____/_____/_____ _____

Signature Date Relation (if not patient)

Copy given to signer: ___/___/_____

Office Use Only:
Authorization received by: ___/___/_____ Initials