Orthopedic Associates
A division of OCC Orthopedic Centers of Colorado

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Please complete entire form

This form is to be use by patients to request confidential communication of their protected health information (PHI). We are required by law to accommodate reasonable requests by individuals to receive communications of protected health information by alternative means or at alternative locations.

I ____, hereby authorize **Orthopedic Associates, LLC**.

To (**Check one**) ☐ release ☐ receive information ☐ to / ☐ from: ___________________________________

Address of receiving party: ____

Form of communication: ☐ Fax Number or ☐ Encrypted e mail: ___________________________

Information pertaining to my care or as requested below:

☐ Office Notes
☐ Operative Records
☐ Laboratory Results
☐ Medication
☐ Other ____
X-rays ☐ **Report** ☐ **Images**
☐ Physical Therapy Notes
☐ MRI, Bone & C.T. Scan Reports
☐ Billing

Intended use of Records:

☐ 2nd Opinion/Continued Care ☐ Personal

The following information may also be released:

☐ I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _______________ **(Initial)**

Patient Legal Printed Name:____

Daytime phone number: _______________________ Date of Birth: ________________________

Signature: ____________________________________ Today's Date: ________________________

- This request is **valid for 1 year from date of signature** unless otherwise noted.
- I may **revoke** this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
- If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be **redisclosed**.
- **There is a fee for copied records for personal use.**
- Please allow 7-10 business days for processing. **There is a $25 fee for a rush processing if needed sooner then 7-10 business days**

Electronic Signature Agreement. By typing your name on this form and selecting the "submit" button, you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature on this form. You further agree that your use of a key pad, mouse or other device to select an item, button, icon or similar act/action, or to otherwise provide disclosures or conditions constitutes your signature (hereafter referred to as "E-Signature"), as if actually signed by you in writing. You also agree that no certification authority or other third party verification is necessary to validate your E-Signature and that the lack of such certification or third party verification will not in any way affect the enforceability of your E-Signature

************************** For Office Use Only **************************

Release scanned to chart ☐ Payment pending ☐ Advisement: _________________

☐ Amount Paid $ ______ ☐ Faxed ☐ Mailed ☐ E-Mailed ☐ Pick up

Completed by: ____________________ Date: _________________