ORTHOPEDIC CENTERS OF COLORADO
Denver Spine Surgeons

MEDICAL RECORD & X-RAY RELEASE

7800 E. Orchard Rd, Suite 100
Greenwood Village, CO 80111
Phone: 303MYSPINE (697-7463)
Medical Records Fax: 303-783-1200

PATIENT IDENTIFICATION:

_____
Name

_____
Social Security #

_____
Birth Date

RELEASE INFORMATION TO:

_____
Name

_____
Address

_____
City/State/Zip

GENERAL AUTHORIZATION: I hereby request and authorize Orthopedic Centers of Colorado, LLC to release my medical records and/or x-ray studies to the above named. I understand that release of this information will no longer guarantee the confidentiality of the information disclosed. I release Orthopedic Centers of Colorado, LLC and its physicians and staff from any and all liability concerning disclosure of this information.

SPECIFIC AUTHORIZATION: ( ) Please initial. Specifically authorize the release of the following information:

____ Alcohol and/or drug abuse, if any
_____ HIV/AIDS status, if any
_____ Psychological or psychiatric conditions, if any

INFORMATION REQUESTED:

_____Copy of office visits
_____Copy of hospital History & Physical, Discharge Summary, Operative Notes
_____Copy of complete chart
_____Copy of imaging studies
_____Other: (specify) _____

A copy/fax of this authorization may be utilized with the same effectiveness as an original.

_____ _____
Signature of Patient/Legally Authorized Person Date

_____ _____
Printed Name of Person Authorized to Sign for Patient How Authorized

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FOR PICK-UP OF MEDICAL RECORDS:

_____
Name of person authorized to pick up records for patient (please print)

I, _____, authorize the above named person to pick up my medical records.

_____Photo I.D. Checked Records released by: _____ Date: _____