Name:
DOB:
Acct #:
Age:
Date:

STEAMBOAT ORTHOPAEDIC & SPINE INSTITUTE

SHAREDID

Authorization For Use or Disclosure of Medical Record Information

Medical Record #

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:

Recipient's Name: _____ 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.*

Information to be Released

Be specific if necessary - include dates of treatment & provider name if applicable.

Date(s) of Treatment _____

☐ Discharge Summary	☐ ER Record	☐ Treatment Plan	☐ Operative Report
☐ Discharge Insructions	☐ Medication Records	☐ Office Notes	☐ Pre-op Notes
☐ Lab Reports	☐ Consultations	☐ History and Physical	☐ Imaging Report(s)
☐ Entire Medical Record	☐ Other:		

Delivery:

☐ Discuss Medical information ☐ Pick-up ☐ Mail ☐ Other:

Expiration Date

This authorization is effective through (check one) ☐ Date _____

☐ NO expiration, unless revoked or terminated by the patient or patient's personal representative.

**I understand the information in my medical record may contain information related to substance abuse or treatment, mental health, or communicable diseases.

Patient's Signature **Date***

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

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

*You may revoke this Authorization at any time.
Provide a written statement to the OSS clinic where the Authorization was originally submitted, except to the extent that OSS 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. OSS will not condition treatment or payment of the provision of this Authorization. Patient does have a right to receive a copy of this form