PANORAMA
Orthopedics & Spine Center

660 Golden Ridge Road
Suite 250
Golden, CO 80401
Medical Records Fax #: 720-497-6734

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

PURSUANT TO 45 CFR 164.508

Patient Name:_____ Date of Birth:_____

Address: _____ SSN: _____

City: _____ State:_____ Zip:_____ Phone:_____

RELEASE RECORDS TO: (Please allow up to 30 business days to complete)

[ ] Patient/Patient's Authorized Representative (fee may apply) [ ] Attorney (fee may apply)

[ ] Healthcare Facility/Physician [ ] Other _____

Name: _____

Address:_____ Phone:_____

City: _____ State: _____ Zip:_____ Fax: _____

I authorize Panorama Orthopedics & Spine Center to release the records indicated below to the individual/entity noted in this authorization (Check all that apply):

Date(s) of Service Requested: _____ Thru: _____ Expiration Date: _____

[ ] Medical Records *only* [ ] X-ray Films *only* [ ] **Both** Medical Records and X-ray Films

[ ] Billing Records [ ] Physical Therapy notes [ ] Other _____

REVOCATION: I understand I may revoke this authorization at any time in writing. Cancellation of this authorization does not apply to any records previously released in reliance of this authorization. For records to be released directly to the patient/patient representative, an expiration date of "NONE" is acceptable. For all others, the maximum period for release of records without an updated authorization is one year. A copy of this form is as valid as the original.

I understand that once my information is released under this authorization, my physician(s) and their employees cannot prevent the re-disclosure of that information.

AUTHORIZATION: I authorize Panorama Orthopedics & Spine Center to release the information marked above to the designated recipient(s).

_____ _____
Signature of Patient/Guardian Relationship to Patient

_____ _____
Today's Date Reason Patient Unable to Sign