



8101 E. Lowry Blvd. # 260  
Denver, CO 80230  
303-214-4500/303-214-4570

11960 Lioness Way #270  
Parker, CO 80134  
720-974-5200/720-974-5239

Authorization/Release for Protected Health Information

Patient Legal Name		Date of Birth
Address		Phone Number
City	State	Zip Code

I hereby authorize Denver-Vail Orthopedics, P.C. to disclose Protected Health Information of the patient listed above to:

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Type of Access Requested:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Entire Record   | <input type="checkbox"/> ER Reports     | <input type="checkbox"/> History and Physical | <input type="checkbox"/> Consult Report    |
| <input type="checkbox"/> X-ray CD \$5.00 | <input type="checkbox"/> Operative Note | <input type="checkbox"/> Lab                  | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Billing Records | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Other                |  |

- I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.
- I understand that this authorization may be revoked by me at any time except the extent that action has been taken in reliance upon it.
- The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
- I understand that there may be a fee involved with the fulfillment of this request. **See fee schedule below.**
- I have read the above and authorize the disclosure of the Protected Health Information.

Expiration: This authorization shall expire upon (check one):

- Fulfillment of this request  
 Date \_\_\_\_\_

If no box is checked this authorization shall expire two years from the date of the signature below.

Date: \_\_\_\_\_

Signature of Patient/Legal Guardian:

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**FEE SCHEDULE:** Fees for duplication of Protected Health Information shall follow the Regulations for Patient Medical Reproduction Fees 6 C.C.R. 10111-1, Chapter 2, Part 5.2.3.4. which states the patient shall pay for the reasonable cost of obtaining a copy of his/her patient record, not to exceed \$14.00 for the first ten or fewer pages, \$.50 per page for pages 11-40, and \$.33 per page for every additional page. Actual postage or shipping cost and applicable sales tax, if any, may be charged. I also understand that if my Protected Health Information is being transferred to another health care facility there will be no charge to me.