CORNERSTONE ORTHOPAEDICS AND SPORTS MEDICINE
3 Superior Drive, Suite 225 Superior, CO 80027 Ph: 303-665-2603 Fax: 303-420-2279

Patient Authorization for Release of Health Records to External Parties

Please be advised we have 30 days to complete delivery of all Medical Records requests, however, we will do our best to accommodate urgent deadlines. If pick up option is selected, Medical Records will call when records are ready.

- I authorize Cornerstone Orthopaedics to disclose information from the health records of:

Patient: _____ **Date of Birth**:_____

To: Self_____ or the following recipient: _____

Address: _____ City, State, Zip: _____

Phone:_____ Fax: _____

Email: _____

- **Action requested for records:** ☐ Electronic Media (disc) ☐ Fax ☐ Mail ☐ Patient Portal ☐ Secure Email
- **Pick up location**: ☐ St. Anthony North 144th Ave Westminster ☐ Lutheran Parkway Wheat Ridge ☐ Superior
- **Treatment Dates:** From: _____ To: _____

Specific information to be released:

- ❑ Entire Health Record (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, **and records from other facilities, including primary care and other specialists in the iPN network**.)
- ❑ Cornerstone Orthopaedics Medical Health Records.

❑ Imaging CD	❑ Operative Reports	❑ Billing Records
❑ Medical Records CD	❑ Laboratory results	❑ Physical Therapy Records
❑ Progress Notes	❑ Photographs /Videotapes	❑ Other (Please Specify):
❑ Radiology Reports	❑ Consultation Reports	_____

I give specific authorization to disclose the following information if applicable:

❑ HIV test results	❑ Documentation of Aids diagnosis	❑ Drug & alcohol abuse treatment records	❑ Psychiatric/Mental Health treatment records

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. **I may revoke this authorization at any time by notifying Cornerstone Orthopedics in writing.**
My treatment will not be based on the completion of this authorization form. If the information to be released by this authorization is re-released by the person or organization that receives it, the information may no longer be protected by Federal or Colorado privacy regulations.

Unless revoked earlier, this authorization is valid for **one year** unless otherwise specified here: _____
I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____
Signature of Patient or Patient Representative **Date**

_____ _____
Printed name of Patient or Patient Representative **Relationship to Patient**