



Douglas E. Hemler, M.D. Board Certified PM&R, Pain Medicine, Electrodiagnostic Medicine

Kyle C. Morgan, D.O. Board Eligible PM&R, Pain Medicine, Electrodiagnostic Medicine

Kirk Prochnio, P.A.-C.

Patient name: _____ Date of birth: _____

From: _____

I. My Authorization

Please disclose the following health care information:

All my health information maintained at your practice (Circle “include” or “exclude” for each of the following)

- Including My health information related to drug abuse
- Including My health information related to alcohol abuse
- Including My health information related to HIV/AIDS
- Including My health information related to psychological or psychiatric conditions, including psychotherapy notes

You may disclose this health information to:

Sports and Orthopedic Rehabilitation, PLLC
2801 Youngfield, Suite 150
Golden, CO 80401 PHONE 303-238-4277 FAX 303-238-4977

Reason for this authorization: _____

This authorization ends: _____

II. My Rights

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization. I may revoke this authorization by writing a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date