STAR Spine & Sport

DOUGLAS E. HEMLER, M.D. KYLE C. MORGAN, D.O.

BOARD CERTIFIED PM&R, PAIN MEDICINE, ELECTRODIAGNOSTIC MEDICINE

KIRK W. PROCHNIO, M.S., P.A.-C.

NONSURGICAL ORTHOPEDICS, INTERVENTIONAL SPINE PROCEDURES, SPORTS MEDICINE, ELECTRODIAGNOSIS, OCCUPATIONAL MEDICINE, PAIN MANAGEMENT, REHABILITATION

Patient name: _____ Date of birth: _____

From: Sports and Orthopedic Rehabilitation, PLLC

2801 Youngfield St, Suite 150

Golden, CO 80401 PHONE 303-238-4277 FAX 303-238-4977

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:

_____

_____

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