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

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