SPINE WEST
Physiatry & Sports Physicians

Phone: (303) 494-7773
Email: contact@spinewest.com
Fax: (303) 494-1104

Boulder Office
5387 Manhattan Circle #200
Boulder, CO 80303

Trust • Care • Excellence

Steamboat Office
940 Central Park Drive Suite 280
Steamboat Springs, CO 80487

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Release to: _____
Address:_____City/State:_____Zip:_____
Phone:_____Fax:_____

Patient Name:_____DOB: _____
I authorize Spine West, LLC to release the information specified below to the organization/individual named on this request.

INFORMATION REQUESTED

- ☐ Complete copy of medical record
- ☐ Physical Therapy notes
- ☐ Impairment Rating
- ☐ Independent Medical Evaluation
- ☐ Imaging Reports
- ☐ Consultation
- ☐ Follow up Notes
- ☐ Procedure Notes
- ☐ EMG
- ☐ Laboratory Reports

Other:_____

If the records are for yourself, please indicate how you would like to receive them:_____
I give specific authorization to disclose the following information

- ☐ HIV Test Results
- ☐ Drug & Alcohol Abuse Treatment Records
- ☐ Documentation of AIDS Diagnosis
- ☐ Psychiatric/Mental Health Treatment Records

PURPOSES FOR WHICH INFORMATION IS TO BE UTILIZED

- ☐ Further Evaluation/Treatment
- ☐ Legal
- ☐ Personal Use
- ☐ Insurance Reimbursement
- ☐ Verify Treatment Status
- ☐ Other

EXPIRATION OR REVOCATION OF AUTHORIZATION

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my previous expressed revocation, this authorization will automatically expire 1 year from the date of my signature unless noted below:

- ☐ On _____ or
- ☐ No longer than _____ days from the date of my signature or under the following conditions_____

Signature: A copy of this authorization (including a facsimile copy) may be used with the same effectiveness as the original.
Please attach a copy of a photo ID for verification purposes.

Patient's signature_____ Date _____

Authorized representative (please print)_____Relationship to patient:_____

Authorized representative signature_____ Date _____

Completed_____