Mapleton Hill Orthopaedics
AUTHORIZATION FOR RECORD RELEASE

I authorize Mapleton Hill Orthopaedics to release the medical records of:

Patient Name: ______________________________ D.O.B.__________

To: Name ______________________________ Phone ____________
Address ______________________________ Fax ____________
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I understand that if the organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that if I am requesting this information for my own personal use, to be picked up by myself or my authorized representative, I will incur a fee pursuant to Colorado Regulation fee structure which is as follows: $14.00 for the first 10 pages and $.50 per page for pages 11 through 40 and $.33 for each additional page thereafter, plus postage. There is no fee for records sent directly to another health care provider.

I understand that this request for information could take approximately 48-72 hours to be processed.

Please release the following information:

- ☐ Most Recent Office Visit Notes Only
- ☐ Complete Clinical Records By the Practitioners of this office; i.e., all office notes, x-ray reports, labs, procedure notes, operative reports, etc.
- ☐ X-Ray Reports, Lab Reports, Operative Reports, Procedure Notes, Etc.
- ☐ All Records, Including Those Sent to This Office From Other Offices
  Records previously obtained from other providers could contain information that may be sensitive to you. This office has not thoroughly read these records. We do not know whether they contain such sensitive information. Furthermore, we have no way of knowing whether the other provider released a complete copy of the record or whether your treating physician here retained a complete copy of the records. However, by checking this box, you are authorizing us to release what outside information we do have on file.

I would like to request that you do NOT release information pertaining to the following:

____

______________________ ______________________________
signature of patient or guardian print patient's name

____
print guardian's name if not patient

______________________ ______________________
date contact phone #

This authorization expires on ____/____/______ (Not to exceed 90 days)