



265 Tanglewood Lane, Suite E-1  
Silverthorne, CO 80498  
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**AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION  
PURSUANT TO 45 CFR 164.508**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ SSN: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**RELEASE RECORDS TO: (Please allow 5 – 7 business days to complete)**

Patient/Patient’s Authorized Representative (fee may apply)     Attorney (fee may apply)

Healthcare Facility/Physician                       Other \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Fax: \_\_\_\_\_

I authorize Panorama Orthopedics & Spine Center to release the records indicated below to the individual/entity noted in this authorization (Check all that apply):

Date(s) of Service Requested: \_\_\_\_\_ Thru: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Medical Records *only*     X-ray Films *only*     **Both** Medical Records and X-ray Films

Billing Records     Physical Therapy notes     Other \_\_\_\_\_

**REVOCATION:** I understand I may revoke this authorization at any time in writing. Cancellation of this authorization does not apply to any records previously released in reliance of this authorization. For records to be released directly to the patient/patient representative, an expiration date of “NONE” is acceptable. For all others, the maximum period for release of records without an updated authorization is one year. A copy of this form is as valid as the original.

I understand that once my information is released under this authorization, my physician(s) and their employees cannot prevent the re-disclosure of that information.

**AUTHORIZATION:** I authorize Panorama Orthopedics & Spine Center to release the information marked above to the designated recipient(s).

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Today’s Date

\_\_\_\_\_  
Reason Patient Unable to Sign