FRONT RANGE CENTER for BRAIN & SPINE SURGERY, P.C. 1313 Riverside Ave., Ft. Collins, CO 80524
(970) 493-1292

Authorization to Release Medical Information

I request and authorize the Front Range Center for Brain & Spine Surgery, P.C. doctor or doctors to release medical information obtained in the course of my examination and treatment to all of the following.

Please note: We will be *unable* to release medical information to persons *not* listed below. Please indicate if access is denied by drawing a line through the item.

My Worker's Compensation carrier (This is ***required*** if you are being seen for a work-related injury.)

Any other insurance company such as a disability insurance company

My current employer or any former employer

My primary and/or referring physician

Any health care people providing services involved in my medical treatment and management

My attorney: _____
Name

My emergency contact person

My parents

My spouse

My adult children: _____
Name(s)

Other: _____

This authorization has been made voluntarily. Any information regarding my treatment or other condition that is not to be disclosed is specifically listed below and I will advise the treating surgeon of such request not to disclose certain information.

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 express revocation, this consent will automatically expire upon satisfaction of the need for disclosure.

_____
Date

X _____
Signature of patient, guardian, or power of attorney

_____
Patient's name, printed

_____
Please print name if other than patient Relationship

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Authorization to Leave Information

I authorize Front Range Center for Brain & Spine Surgery, P.C., to leave messages containing medical information as follows. ***Please check all authorized source(s) below:***

- ☐ home voice mail/answering machine
- ☐ business voice mail/answering machine
- ☐ cell phone voice mail
- ☐ email at: _____
- ☐ with an individual I designate as follows: _____

I understand that these messages may include, but would not necessarily be limited to, the following: radiologic test results, lab results, pre- and post-operative care instructions, and suggested courses of treatment.

I further authorize Front Range Center for Brain & Spine Surgery, P.C., to leave messages regarding issues of healthcare business, such as insurance authorizations and account management, on my voice mail, answering machine, or by email.

This authorization has been made voluntarily, and I understand that I may change the choices/information above by notifying Front Range Center for Brain & Spine Surgery, P.C., in writing.

_____
Date

x _____
Signature of patient, guardian, or power of attorney

_____
Patient's name, printed

_____
Person authorized to sign for the patient Relationship

Consent To Release Medical Records from Other Providers:

I realize that records obtained from **other** providers and incorporated as part of the record of the Front Range Center for Brain & Spine Surgery, P.C. could contain information that I may consider sensitive. I understand that the Front Range Center for Brain & Spine Surgery, P.C., may not have had reason to thoroughly read the records they obtained from other providers, may not know if the records contain information I consider to be sensitive, or may not know if other providers have given them a complete copy of my previous records. By my signature below, however, I authorize the Front Range Center for Brain & Spine Surgery, P.C., to release information from other providers.

x _____
Signature

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