COLORADO SPRINGS ORTHOPAEDIC GROUP
6011 East Woodmen Road, #120 – Colorado Springs, CO 80923

INSURANCE ASSIGNMENT OF BENEFITS RELEASE OF MEDICAL INFORMATION

I authorize the release of any medical information that is in any way related to my physical and mental health status, which is in the possession of any other medical provider and may be requested in order to process this medical insurance claim. A copy of this authorization will be sent to HCFA, my insurance company or other entity, if requested. The original will be kept on file by Colorado Springs Orthopaedic Group.

I authorize payment of my medical benefits to Colorado Springs Orthopaedic Group. I also am aware that if my insurance does not cover services provided, or if Colorado Springs Orthopaedic Group does not accept assignment, I am responsible for all charges incurred. It is my responsibility to notify Colorado Springs Orthopaedic Group of any changes in my health insurance coverage.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPPA) to ensure that I have been made aware of my privacy rights.

Patient Signature: ____ Date: ____________________
Or Patient's Authorized Signature (Parent/Legal Guardian)