



**AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION**

Physician or Facility to provide records: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ SSN#: \_\_\_\_\_ DOB: \_\_\_\_\_

Person to Pickup Records: \_\_\_\_\_ Relationship: \_\_\_\_\_

I authorize the health care provider to release the information specified below to the organization, agency, or individual named on this request. I specifically authorize the release of information regarding the following condition(s):

Initials

\_\_\_\_\_ Drug Abuse (if any)

\_\_\_\_\_ Psychological/Psychiatric Condition (if any)

Initials

\_\_\_\_\_ Substance Abuse (if any)

\_\_\_\_\_ AIDS/HIV (if any)

Release these records:

1. All medical records at this facility.
2. Only records generated by this facility
3. Only some portions of records maintained at this facility.

Initials

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Specify which records: \_\_\_\_\_

**EXPIRATION OR REVOCATION OR AUTHORIZATION:** I understand that I may revoke this authorization at any time.

**USE OF COPIES:** A copy of this authorization may be utilized with the same effectiveness as an original.

Name: (Print) \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Check: \_\_\_\_\_ Patient \_\_\_\_\_ Parent \_\_\_\_\_ Guardian

**MAIL OR FAX RECORDS TO: 2315 E Harmony Rd, Suite 110, Ft Collins, CO 80528**  
**970.212.7600 FAX 970.212.7637**