



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