

Request for Medical Records from Health Care Provider

Release Medical Records to:

Rocky Mountain Family Physicians, P.C.
1124 East Elizabeth, Building C
Fort Collins, CO 80524
Phone: (970) 484-0798 Fax: (970) 482-0679

I authorize _____
Physician or Facility (Must have complete name, address and phone number)

Address

City	State	Zip	Telephone
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To release the following medical records on:

Patient's Name(s)	DOB
_____ Last Name	____/____/____ First Name
_____	DOB ____/____/____
_____	DOB ____/____/____

I authorize the above named facility to release the information specified below to Rocky Mountain Family Physicians, P.C. I specifically authorize the release of information regarding the following condition(s):

Initials	Initials
_____ Drug abuse, if any	_____ Substance abuse, if any
_____ Psychological or psychiatric conditions, if any	_____ AIDS/HIV, if any

Release these records:	CHOOSE ONE	Initials
1. Last physical, last eight office visits, any surgeries, problem sheet, medication sheet, immunization records, any blood work, pap smears/biopsies, x-rays, mammograms done from last year (Preferred)	_____	_____
2. All medical records at this facility	_____	_____
3. Only some portion of records maintained at this facility (specified below):	_____	_____

Expiration or revocation of authorization: I understand that I may revoke this authorization at any time in writing. If I do, it will not affect any actions already taken by the above named practice based on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, fill out a revocation form at Rocky Mountain Family Physicians, P.C.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information may not be protected by federal confidentiality rules.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment.

Person authorized to sign for patient(s): (If patient is over 18, then patient must sign below)

Print or type name	Relationship	Signature	Date
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