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**

To release the following medical records on:

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

____

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