Request for Medical Records from Rocky Mountain Family Physicians, P.C.
PLEASE NOTE: Personal records requests are subject to a $10 fee.

I authorize Rocky Mountain Family Physicians, P.C. (RMFP) to release the following medical records to:

_____

Physician or Facility or Self (Must have complete name, address and telephone number)

_____

Address

_____

City **State** **Zip** **Telephone**

For the following patient(s):

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

_____

I authorize RMFP to disclose the following specified health care information below to the above named organization/individual on this request. 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. Only the records generated by this facility (**not** including records received from other sources) _____
2. All medical records at this facility
   Please be aware that information received from other sources may contain sensitive information about you. RMFP does not know the exact content of this information, or if the released information is a complete copy. However, by initialing you are authorizing us to release this information. _____
3. Only some portion of records maintained at RMFP (specified below): _____

   _____

   _____

   _____

Authorization ends on _____/_____/_____

_____

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.

Are you transferring records because you are leaving our practice? _____ yes _____ no
If you are choosing to leave our practice, please tell us why so we may try to prevent this from happening again:

_____

_____

Person authorized to sign for patient(s): (If patient is over 18, then patient must sign below unless we have a Power of Attorney)

_____	_____	_____	_____
Print or type name	Relationship	Signature	Date

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