ROCKY MOUNTAIN FAMILY PHYSICIANS

MEDICAL RECORDS RELEASE FORM

I authorize the following medical records to be sent:

For the following patient: Patient Name: _____ DOB_____

FROM:

- □ Rocky Mountain Family Physicians, P.C. 1124 E. Elizabeth St, Bldg. C Fort Collins, CO 80524
- □ Other: Physicians or Facility Name _____
  Address _____
  _____
  Phone Number: _____ Fax Number: _____

TO:

- □ Rocky Mountain Family Physicians, P.C. 1124 E. Elizabeth St, Bldg. C Fort Collins, CO 80524
  Phone: 970-484-0798 Fax: 970-482-0679
- □ Other: Physicians or Facility Name _____
  Address _____
  _____
  Phone Number: _____ Fax Number: _____

I authorize the following records to be released to the above-mentioned physician of facility:
(Please Only Select ONE)

- □ Only the records generated by this facility (NOT including records retrieved from other sources).
- □ ALL medical records at this facility. *Please be aware that information retrieved from other sources may contain sensitive information about you and by selecting this option, you are authorizing us to release this information.*
- □ Only some portion of records (Specified Below):
  _____
  _____
  EXCLUDING THE FOLLOWING:
- □ Drug Abuse
- □ Psychological or Psychiatric Conditions
- □ Substance Abuse
- □ AIDS/HIV

This 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 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.

Person Authorized to Sign for Patient:
(If patient is over 18, then the patient MUST sign below unless there is a Power of Attorney on file)

Print Name: _____ Relationship _____
Signature: _____ Date: _____