26659 Pleasant Park Rd
Conifer, CO 80433
Phone: (303) 647-5300
FAX: (877) 892-7288

Patient Full Name: ______________________ **DOB**: ____________

Previous/Other Name: ______________________ **Phone**: ____________

(If different than patient listed above)

To Release From:

Facility: ______________________

Phone: ______________________

FAX: ______________________

To Release to:

Facility: ______________________

Phone: ______________________

FAX: ______________________

GENERAL INFORMATION REQUESTED

Medical Information Requested:	Reason for Release:
☐ Complete records	☐ Changing doctor
☐ Partial record: dates and/or specific records	☐ Dissatisfaction with care
☐ X Ray reports	☐ My insurance changed
☐ Partial records	☐ Specialist consult

Other: ______________________

____

I am moving, new address: ______________________

____

AUTHORIZATION FOR RELEASE OF SPECIFIC INFORMATION PROTECTED BY FEDERAL LAW

I specifically authorize the release of information relating to (Note, you must mark yes or no):

☐ Yes	☐ No	Substance Abuse (alcohol/drug abuse)
☐ Yes	☐ No	Mental Health/Depression (includes psychological testing)
☐ Yes	☐ No	HIV-Related Information (AIDS related testing)
☐ Yes	☐ No	Sexually Transmitted Diseases

This consent may be revoked at any time by notifying the above-named provider of information in writing. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.

RESTRICTIONS:
The authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

Signature of Patient or Responsible Party: ______________________

Today's Date: ______________________

Date Authorization Ends: ______________________