

AUTHORIZATION TO REQUEST/RELEASE MEDICAL INFORMATION

Coal Creek Family Medicine

1044 S. 88th Street, Suite 200

Louisville, CO 80027

PHONE: 303-666-7119 **FAX: 303-666-5995**

PATIENT FIRST AND LAST NAME (Please Print): _____

BIRTHDATE (MM/DD/YEAR): _____

INFORMATION AUTHORIZED FOR RELEASE: (Please Initial)

_____ ALL RECORDS

_____ LAB RESULTS

_____ PATHOLOGY RESULTS

_____ HIV TESTING

_____ OB/GYN RECORDS

_____ OTHER

REQUESTING FROM: (Print name & address of Doctor or Health care facility):

Address:

**Coal Creek Family Medicine 1044 South 88th
Street, STE 200,
Louisville, CO 80027**

**FAX #: 303-666-5995
Phone #: 303-666-7119**

RELEASE RECORDS TO: (Print name, address of Individual & fax, Doctor or Health care facility to whom records are to be released to): ATTN: _____

Address: _____

FAX #: _____ **Phone #:** _____

****FAX NUMBER IS NEEDED TO COMPLETE REQUEST****

AUTHORIZATION – I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. I understand that unless specified below this consent will expire 180 days from the date of signature. I hereby release the health care provider from any liability, which may result from furnishing the information requested as authorized in this release. The health provider cannot be responsible for misuse of this information disclosed pursuant to this release.

Date Signature of Patient OR Person Authorized to Sign for Patient

Address Relationship to Patient

City, State, Zip Code Phone

Please FAX 15 pages or less and mail if over 15 pages.

****One Patient per Medical Records Request Form Only****

Please allow up to 10-business days to complete request.