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: ______________________________

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**FAX #:______________________________ Phone #:______________________________

MUST HAVE THE FAX NUMBER TO COMPLETE

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

Please Enter Providers Name

Address:

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

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

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