AUTHORIZATION TO REQUEST/ RELEASE MEDICAL INFORMATION

Coal Creek Family Medicine
1044 S. 88th Street, Suite 200
Louisville, CO 80027
PHONE: 303666-7119 ***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

ARE YOU PERMANENTLY TRANSFERING PCP'S _____ YES _____ NO

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

Address:

Coal Creek Family Medicine
1044 S. 88th St., Suite 200
Louisville, CO 80027

FAX #: 303-666-5995
Phone #: 303-666-7119
Email: medicalrecords@coalcreekfamilymedicine.com

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 authorization in this release. The health provider cannot be responsible for misuse of this information disclosure pursuant to this release.

_____ _____ OR _____
Date Signature of Patient Person Authorized to Sign for Patient

_____ _____
Address Relationship to Patient

_____ _____
City, State, Zip 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.