Coal Creek Family Medicine

REQUEST FOR MEDICAL RECORDS FORM

1044 S. 88th Street, Suite 200
Louisville, CO 80027
PHONE: 303-666-7119 *FAX: 303-666-5995*
medicalrecords@coalcreekfamilymedicine.com

PATIENT FIRST AND LAST NAME (Please Print): _____

BIRTHDATE (MM/DD/YEAR): _____

INFORMATION AUTHORIZED FOR RELEASE: (Please Initial)

_____ All Records (Last 2 years) _____ Lab Results _____ Immunization Record _____ Billing Records

Other: _____

_____

Purpose of Release: _____ Transfer of care to a new provider _____ For Personal Records ($25 processing fee)
_____ Continuation of Care _____ Referral

REQUESTING FROM:
Name of Doctor or Facility: _____

Address: _____

_____

Phone : _____ Fax: _____

RELEASING TO:
Name of Doctor or Facility: _____

Address: _____

_____

Phone : _____ Fax: _____

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.

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

_____ Address _____ Relationship to Patient

_____ City, State, Zip _____ Phone

One Patient per Medical Records Request Form Only

If you are sending records to CCFM: Please e-mail or fax if over 60 pages