1044 S 88th St Suite 200
Louisville, CO 80027
Phone (303)666-7119
Fax (303)666-5995

Coal Creek Family Medicine

Marcie Lavigne, MD
Lisa Talamantes, MD
Kevin Boehm, MD
Carl Meredith, MD
Debra Neeland, PA-C
Katrina Rosin, PA-C

MEDICAL RECORDS RELEASE FORM

PATIENT FIRST AND LAST NAME (Please Print): _____

BIRTHDATE (MM/DD/YEAR): _____

INFORMATION AUTHORIZED FOR RELEASE:

_____ Most Recent Wellness Exam _____ Last 3 Clinical Notes _____ Immunizations _____ All Laboratory Reports

_____ GI Studies _____ Mammograms _____ Bone Density Scans

_____ ADD/ADHD Assessments _____ Cardiology Reports _____ Growth Charts _____ PAPs

Other: _____

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

REQUEST RECORDS FROM: (Check one)

☐ Coal Creek Family Medicine
1044 S 88th St Suite 200
Louisville, CO 80027
Phone: (303)666-7119
Fax: (303)666-5995

☐ Name of PCP or Facility: _____
Address: _____
_____
Phone: _____
Fax: _____

RELEASE RECORDS TO: (Check one)

☐ Coal Creek Family Medicine
1044 S 88th St Suite 200
Louisville, CO 80027
Phone: (303)666-7119
Fax: (303)666-5995

☐ Name of PCP or Facility: _____
Address: _____
_____
Phone: _____
Fax: _____

medicalrecords@coalcreekfamilymedicine.com

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
_____ Person Authorized to Sign for Patient
_____ Address
_____ Relationship to Patient
_____ City, State, Zip
_____ Phone

One Patient per Medical Records Request Form Only