Coal Creek Family Medicine

1044 S 88th St. Suite 200, Louisville, CO 80027
Phone: (303)666-7119 Fax: (303)666-5995
medicalrecords@coalcreekfamilymedicine.com

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

Authorization for Release of Protected Health Information

Patient Name (Please Print): _____DOB (MM/DD/YEAR): _____

If Minor, Parent or Legal Guardian Name: _____ Relation: _____

Address: _____ City/State: _____Zip: _____

Preferred Phone #: _____

Information Authorized for Release

Dates of Service (Month/Year) From: _____ To: _____

_____ Complete Record
_____ Clinic Progress Notes
_____ Laboratory Results
_____ Immunization Record
_____ Growth Charts
_____ PAP/HPV Results
_____ Mammography Reports
_____ Bone Density Scans
_____ Colonoscopy Reports
_____ Mental Health Records
_____ ADD/ADHD Assessments
_____ Medications Prescribed
_____ Cardiology Studies
_____ Billing Records
_____ Demographic Sheet
_____ Other: _____

Purpose of Release

_____ Permanent Transfer
_____ Disability Determination
_____ Referral to a Specialist
_____ Legal Investigation
_____ Continuation of Care
_____ Personal Copy ($25 processing fee)

Requesting From:
Name of Practice/Facility/Provider:

_____

Address: _____

_____

Phone Number: _____

Fax Number: _____

E-mail: _____

Releasing To:
Name of Practice/Facility/Provider:

_____

Address: _____

_____

Phone Number: _____

Fax Number: _____

E-mail: _____

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.

_____ _____
Patient or Legally Authorized Individual Signature **Date**

One patient per Medical Record Request form only
If you are requesting records from CCFM, please allow up to 7 business days for processing