



Coal Creek Family Medicine

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### 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: \_\_\_\_\_

- |  |   |
|--|---|
| <input type="checkbox"/> Complete Record       | <input type="checkbox"/> Colonoscopy Reports    |
| <input type="checkbox"/> Clinic Progress Notes | <input type="checkbox"/> Mental Health Records  |
| <input type="checkbox"/> Laboratory Results    | <input type="checkbox"/> ADD/ADHD Assessments   |
| <input type="checkbox"/> Immunization Record   | <input type="checkbox"/> Medications Prescribed |
| <input type="checkbox"/> Growth Charts         | <input type="checkbox"/> Cardiology Studies     |
| <input type="checkbox"/> PAP/HPV Results       | <input type="checkbox"/> Billing Records        |
| <input type="checkbox"/> Mammography Reports   | <input type="checkbox"/> Demographic Sheet      |
| <input type="checkbox"/> Bone Density Scans    | <input type="checkbox"/> Other: _____           |

#### Purpose of Release

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Permanent Transfer       | <input type="checkbox"/> Referral to a Specialist | <input type="checkbox"/> Continuation of Care                |
| <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Legal Investigation      | <input type="checkbox"/> 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\***