Authorization for Release and Request for Medical Information

I hereby authorize and request to furnish the protected health information of:

Name of Patient *(Please Print)*:____
DOB:_____________ Social Security #:_____________ Phone Number:______________
Address:____

You may use or disclose the following health care information *(check all that apply)*:

- ❏ All my health information
- ❏ Other:

  ____

Reason for this authorization:____

Release Records **FROM**:

Name:____
Address:____
City:___________________ State: ______________________
Phone:______________________ Fax:___________________

Send Records **TO**:

Name:____
Address:____
City:___________________ State: ______________________
Phone:______________________ Fax:___________________

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do hereby voluntarily authorize disclosure of the above information about or medical records of my conditions to those persons or agencies listed above.

____ _____________________
Patient or legally authorized representative signature Date

10099 Ridge Gate Parkway, Suite 365, Lone Tree, CO, 80124, (P) 303-797-1150 (F) 303-797-0169