

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME (Last, First): \_\_\_\_\_  
FORMER NAME (Last, First): \_\_\_\_\_  
BIRTH DATE (dd MMM yy): \_\_\_\_\_  
SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
CURRENT ADDRESS: \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
PHONE: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

## THIS REQUEST AND AUTHORIZATION REFERS TO:

- Health care information relating to the following treatment, condition, or dates of treatment:  
\_\_\_\_\_
- All health care information
- Other: \_\_\_\_\_

REASON FOR RELEASE: \_\_\_\_\_

	MEDICAL RECORDS FROM:	MEDICAL RECORDS TO:
Dr or clinic name:	A Woman's Place of Fort Collins, PLLC	_____
Address:	1224 E Elizabeth St	_____
City, State, Zip:	Fort Collins CO 80524	_____
Phone #:	(970) 221-4977	_____
Fax #:	(970) 221-4980	_____

I understand that these records may contain information regarding the diagnosis or treatment of HIV (AIDS Virus), other sexually transmitted diseases, drug and/or alcohol abuse and/or treatment, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. I understand that this request for release is effective for 90 days. SIGNATURE OF THE PATIENT IS REQUIRED OF ALL PATIENTS 18 YEARS OF AGE OR OLDER. PARENT OR LEGAL GUARDIAN MAY PROVIDE AUTHORIZING SIGNATURE IF THE PATIENT IS A MINOR.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

\_\_\_\_\_  
DATE SIGNED

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE SIGNED

There is a charge for copies of records from A Woman's Place. Information in the records is the patient's property. The medical record itself is the physician's property.  
FEE SCHEDULE (established by the Colorado Medical Society: \$14 FOR THE FIRST 10 PAGES, \$0.33 FOR EACH ADDITIONAL PAGE THEREAFTER.