

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.