

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT NAME: _____ DOB: _____

PATIENT ADDRESS: _____

HOME NUMBER: _____ CELL: _____

A FEE WILL BE CHARGED FOR RECORDS NOT RELEASED TO A HEALTH CARE PROVIDER

RECORDS TO:

RECORDS FROM:

**WESTSIDE WOMEN'S CARE
7950 KIPLING STREET SUITE 201
ARVADA, CO. 80021**

I AUTHORIZE WESTSIDE WOMEN'S CARE TO RELEASE THE INFORMATION SPECIFIED BELOW TO HEALTH CARE PROVIDER. I SPECIFICALLY AUTHORIZE THE RELEASE OF INFORMATION REGARDING THE FOLLOWING CONDITION(S).

INITIALS

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_____ DRUG ABUSE

_____ SUBSTANCE ABUSE

_____ PSYCHOLOGICAL CONDITIONS

_____ AIDS/HIV

PLEASE RELEASE THE FOLLOWING RECORDS:

INITIALS

_____ ALL MEDICAL RECORDS AT THIS FACILITY

_____ ONLY RECORDS GENERATION BY THIS FACILITY

_____ ONLY SOME PORTIONS OF RECORDS AT THIS FACILITY (SPECIFY BELOW)

WILL YOU BE TRANSFERING FROM OUR PRACTICE? _____

AUTHORIZATION EXPIRES 90 DAYS FROM DATE OF SIGNATURE

PATIENT SIGNATURE: _____ DATE: _____

PERSON AUTHORIZED TO SIGN FOR PATIENT:

PRINT NAME: _____ RELATIONSHIP: _____

SIGNATURE: _____ DATE: _____

