

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT NAME: _____ DOB: _____

PATIENT ADDRESS: _____

HOME NUMBER: _____ CELL: _____

RECORDS TO:

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

RECORDS FROM:

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

INITIALS

_____ DRUG ABUSE

_____ PSYCHOLOGICAL CONDITIONS

INITIALS

_____ SUBSTANCE ABUSE

_____ 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: _____

