Westminster Office
10081 Wadsworth Pkwy, Ste 200
Westminster CO, 80021
Phone 303-431-5409
Fax 303-453-4994

Arbor FAMILY MEDICINE

Thornton Office
3655 East 104th Ave, Suite A
Westminster CO, 80233
Phone 303-254-8500
Fax 303-453-4994

AUTHORIZATION TO RECEIVE MEDICAL RECORDS/INFORMATION

I authorize the release of my medical records by the organization or physician listed below:

Physician's Name: _____

Physician'sAddress:_____

Physician's Phone #: _____ Fax # of Physician: _____

Reason for Records Release:_____

These records are to be sent to Arbor Family Medicine at the Thornton/Westminster Office at the address listed above.

Patient's Name: _____Date Of Birth: _____

Address:_____State:_____Zip Code:_____

Social Security #: _____Phone#:_____

The type and amount of information to be disclosed is initialed as follows: (specify dates where appropriate)

____ X-Ray films (Specify type/date)
____Immunizations
____Most recent 3 years of Records
____Entire Medical Record
____ Substance and Drug Abuse, if any
____ AIDS/HIV, if any
____ Genetic testing, from date
____Psychological or psychiatric conditions, if any

Other:_____

I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I accept full financial responsibility for any copying or shipping fees and any applicable sales tax that may be charged.

_____ _____
Patients Name **Today's Date**

_____ _____
Patient's Parent/Guardian/Representative **Relationship to Patient**