West Office
10081 Wadsworth Pkwy #200
Westminster, CO 80021
P: 303.431.5409
F: 303.453.4994

Arbor Family Medicine, PC

East Office
3655 E. 104th Ave Ste A.
Thornton, CO 80233
P: 303.254.8500
F: 303.453.4994

AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

Patient's Name: _____ Phone #: _____

Address: _____

Social Security # (Last 4 Digits): _____ DOB: _____

I authorize *Arbor Family Medicine to RELEASE* my medical records to the following Physician/Organization:

Name: _____

Address: _____

Phone #: _____ Fax #: _____

Reason for Disclosure of Records: _____

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

___Entire Medical Record (includes all Patient Information listed below)
___X-Ray films (Specify type/date)
___Immunizations
___Most recent 2 years of Records
___ Most recent labs
___Substance and Drug Abuse, if any
___AIDS/HIV, if any
___Genetic testing, from date_____
___ Psychological or psychiatric conditions

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 treatment, payment, enrollment or eligibility of benefits will not be conditioned in obtaining your authorization for release of records.
I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by federal confidentiality rules.

*Pre-payment is ***Required*** for release of records to the individual patient for personal use.
Records on CD cost $14.00 + 1.09 postage. A total of $15.09 If you would like your records printed the cost is $14.00 for the first 10 or fewer pages, $0.50 per page for pages 11-40 and $0.33 per page for every additional page.
** Requests will be completed within 30 days.

_____ _____
Patient or Patient Representative's Signature Today's Date

_____ _____
Representative's Name (PRINT) Relationship to Patient (PRINT)