Walnut Ridge Family Medicine

Name _____ Date of Birth _____

Phone _____ _____

Day Night

Authorization for Release of Patient Information

Released from:	Released to:
Walnut Ridge Family Medicine	Facility Name: _____
7110 West 44th Avenue	Address: _____
Wheat Ridge, CO 80033	_____
Phone: 720-593-1994	Phone: _____
Fax: 866-612-4062	Fax: _____

Please check one:

☐ Mail records ☐ Fax records

Information Requested:

_____ Complete Chart _____ History and Physical _____ Diagnostic studies

_____ X-ray Reports _____ Lab Reports _____ Psychological Evaluation

_____ Pathology Reports _____ Doctors Notes _____ Operative Reports

Treatment Date(s): _____

Purpose of Release: _____Treatment/Diagnosis _____Insurance _____Legal _____Other

I know that I have the right to revoke this authorization and statement. In order to revoke this authorization, I will just have to send a letter to my physician stating my intentions. I request and authorize the release of information to the organization, agency or individual named above. I understand that the information to be released may include the following condition(s): Drug Abuse/Alcohol abuse, Psychological or psychiatric conditions, Test for the presence of antibodies (HIV virus which causes AIDS), and AIDS diagnosis and/or an AIDS related condition. This authorization will expire 1 (one) year from the date of signature.

_____ _____

Signature of Patient/Guardian Relationship Date

NOTE: All parts of form must be completed for transfer of records.