AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name (Last, First): _____
Former Name (Last, First): _____
Birth Date (dd/mm/yyyy): _____
Social Security Number: _____
Current Address: _____
City, State, Zip: _____
Phone: _____

THIS REQUEST AND AUTHORIZATION REFERS TO:

➢ Health care information relating to the following treatment, condition, or dates of treatment: _____
➢ All health care information
➢ Other : _____

REASON FOR RELEASE: _____

MEDICAL RECORDS FROM: **MEDICAL RECORDS TO:**

Dr or clinic name:
Northern Colorado Women's Wellness
1175 58th Ave Suite 101
Greeley CO 80634 _____

I understand that these records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse and/or treatment, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. SIGNATURE OF THE PATIENT IS REQUIRED OF ALL PATIENTS 18 YEARS OF AGE OR OLDER. PARENT OR LEGAL GUARDIAN MAY PROVIDE AUTHORIZING SIGNATURE IF PATIENT IS A MINOR.

_____ Date signed
Signature of patient or authorized representative

_____ Date Signed
Witness

There is a charge for copies of records from this clinic for copying records. Information in the records is the patent's property. The medical record itself is the physician's property.
FEE SCHEDULE (established by the Colorado Medical Society: $14 for the first 10 pages, $0.25 for each additional page thereafter.