AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
To: NoCo Women's Wellness

Patient Name (Last, First)_____
Former Name (Last, First _____
Birth Date (dd/mm/yyyy)_____
SSN _____
Current Address_____
City, State, Zip_____
Home Phone_____Cell_____Other_____

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:

Dr. or clinic name_____
Address_____
City, State, Zip_____
Phone_____
Fax _____

MEDICAL RECORDS TO:

NoCo 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.

_____
Signature of patient or authorized representative Date signed

_____
Witness Date Signed

There is a charge for copies of records from NoCo Women's Wellness. 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.