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**** FAXED OR MAILED RECORDS RELEASE MUST BE ACCOMPANIED BY PARENT OR GUARDIAN PICTURED ID & WITNESS FULL SIGNATURE, ADDRESS, PHONE NUMBER ****

Consent to Release Information Mail Pick Up - Date _____

Allow 5 Working Days

I hereby authorize:

To release to:

Name

Name

Address

Address

This is to authorize you to release the requested information on the below named individual(s):

(One patient per line. If you need more space, please enter information on the back.)

Patient Name

Date of Birth

Information Requested:

- Records for specialist **referral**
- Standard Records (last 3 yrs. office visits, physicals, growth chart, vaccines, problem list, labs, hospital notes)
- Limited Records (event, dates: _____)
- Complete Records (copying fee charged)
- Immunization Records
- Psychiatric Records

Reason(s):

- Referral
- Consult
- Moving
- Age
- Changing Doctors
- Insurance
- Dissatisfied. Reason _____
- Other _____

I request and authorize the above named provider/s to release this information. I understand the records may include information regarding the following conditions: drug or alcohol abuse, psychological or psychiatric conditions, developmental disabilities, HIV, AIDS, sexually transmitted diseases, pregnancy or other sensitive information. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment, my eligibility for benefits, etc. will not depend in any way on whether I sign this authorization or not. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. This authorization will expire 120 days from the date below.

Print Name

Relationship to Patient

Signature

Date

Phone Number

Witness Signature

Date

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to address or name of office. _____

Signature

Date