Red Canyon Family Medicine

a division of PRIMARY CARE PARTNERS, P.C.

P.O. Box 10700 • Grand Junction, Colorado 81502-5517
Phone: (970)256-5285 • Fax: (970)256-5290

** FAXED OR MAILED RECORDS RELEASE MUST BE ACCOMPANIED BY PARENT OR GUARDIAN PICTURED ID & WITNESS SIGNATURE **

Consent to Release Information ☐ Mail ☐ Pick Up ☐ Fax

Please Allow 5 Working Days

Please get health information from / give health information to:

_____
Name

_____
Address

_____

_____
Phone **Fax**

REQUIRED: Check only one box

I give permission to Red Canyon Family Medicine to:

☐ Obtain (get) information

☐ Release (give) information

☐ Exchange (share) information

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
☐ Limited Records can be copied to a flash drive (Allergies, Immunizations, Medications, Results, Vitals, Past Surgical, Social, Family, Past Medical histories, and Active Problem list)

First copies no charge; any extra copies will include a copying Fee

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

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