Records Release Authorization

PRIMARY CARE PARTNERS

3150 N. 12th Street • Grand Junction, Colorado 81506
P.O. Box 10700 • Grand Junction, Colorado 81502
Medical Records | P: (970) 256-5240 | F: (970) 778-3136

* FAXED OR MAILED RECORDS RELEASE SHOULD BE ACCOMPANIED BY PICTURE ID (OR THAT OF A PARENT/GUARDIAN) & WITNESS SIGNATURE *

I give permission to Primary Care Partners to: (check one)	Name	
☐ Obtain (get) information	Address	
☐ Release (give) information		
☐ Exchange (share) information	Phone	Fax

This authorizes the release of the requested information on the individual(s) below:
(One patient per line. If additional space is needed, please use back of form)

Patient Name _____ DOB _____

Patient Name _____ DOB _____

Information Format: ☐ Mail ☐ Pick up ☐ Fax ☐ Email ☐ USB drive

Information Requested:

☐ Standard Records (last 3 yrs. office visits, physicals, growth chart, vaccines, problem list, laboratory results, radiology reports, hospital notes)
☐ Limited Records (event, dates: _____)
☐ Complete Records
☐ Immunization Records
☐ Psychotherapy Notes
☐ Radiology Images (date: _____) Primary Care Partners can only provide images for tests we have conducted. For radiology done by a third party, please request the images directly from them.

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 1 year from the date below.

First copies are at no charge. I understand that I may be charged a reasonable fee per rates set by the Colorado State Board Health after the first courtesy release for: paper copies or transfer, electronic records, or mailing (includes postage/materials).
☐ I hereby agree to pay the charges specified above. Please bill me. ☐ Please contact me with total incurred cost

Print Name _____ Relationship to Patient _____

Signature _____ Date _____

Witness Signature _____ Date _____