FAX # 1-970-826-7026
AUTHORIZATION TO RELEASE MEDICAL RECORDS*

I, _____, _____/_____/_____
(PATIENT NAME) (DATE OF BIRTH)
Authorize the health care provider to release the information specified below to the organization, agency or individual named on this request.
Initial all that apply:
_____ Standard Records (Last Five years).
_____ All Records (Not including records from other physicians).
_____ Previous Physical Therapy Records.
_____ Specific Services

** Patient reserves the right to revoke permission in writing at any time. However, we cannot take back any disclosures we have already made.
** Records may include AIDS/HIV, STD, psychiatric, and substance abuse information. Please specify if you DO NOT want any or part of these records to be included. _____Initial if you DO NOT release AIDS/HIV,STD, psychiatric & substance abuse records.

_____ PLEASE INITIAL THAT YOU UNDERSTAND THE ABOVE.

Records Released From: Send To:

_____ _____
(FACILITY OR DOCTOR'S NAME) (FACILITY OR DOCTOR'S NAME)

_____ _____
(MAILING ADDRESS) (MAILING ADDRESS)

_____ _____
(CITY, STATE AND ZIP) (CITY, STATE AND ZIP)

PHONE:_____ PHONE:_____

FAX:_____ FAX:_____

_____ _____
(SIGNATURE) (DATE**)

*We reserve the right to charge a fee for copying.
**This release will automatically expire on year from the date signed.