West Office
10835 Dover St, Suite 1100
(108th and Wadsworth Blvd)
Westminster, CO 80021
P: 303.431.5409
F: 303.431.1914

Arbor Family Medicine, PC

East Office
3655 E. 104th Ave
(104th and Colorado Blvd)
Thornton, CO 80233
P: 303.254.8500
F: 303.453.4994

AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

I authorize *Arbor Family Medicine to RELEASE* my medical records to the following physician:

Physician's Name: ____

Physician's Address: ____

Physician's Phone #: ____________________ Fax # of Physician: ____________________

Reason for Records Release____

Patient's Name: ______________________________ Phone #: ______________

Address: ____

Social Security #: ______________________________ DOB: ____________________

The type and amount of information to be disclosed is initialed as follow:(specify dates where appropriate)

___ X-Ray films (Specify type/date)
___Immunizations
___Most recent 3 years of Records
___Entire Medical Record

___Substance and Drug Abuse, if any
___AIDS/HIV, if any
___Genetic testing, from date
___ Psychological or psychiatric conditions, if any

Other: ____

I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company.

I understand that treatment, payment, enrollment or eligibility f benefits will not be conditioned on obtaining your authorization for release of records.

I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I accept full financial responsibility for copying fees. Shipping and applicable sales tax will also be charged.

Patient name (Print): ____________________ Date: ____________________

Patient's (or Representative) Signature: ____

Patient's Representative (Print): ____________________Relationship to Patient: ____________