

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 RECEIVE MEDICAL RECORDS/INFORMATION

I authorize the release of my medical records by the organization or physician listed below:

Physician's Name: _____

Physician's Address: _____

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

Reason for Records Release _____

These records are to be sent to Arbor Family Medicine at the Thornton / Westminster Office at the address above.

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)

____ Substance and Drug Abuse, if any

____ Immunizations

____ AIDS/HIV, if any

____ Most recent 3 years of Records

____ Genetic testing, from date

____ Entire Medical Record

____ 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 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 any copying fees. Shipping and applicable sales tax may also be charged.

Patient name (Print): _____ Date: _____

Patient's (or Representative) Signature: _____

Patient's Representative (Print): _____ Relationship to Patient: _____