Authorization for Release of Medical Records

Patient Information

Last	First	M.I.	Date of Birth
			/ /

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Release To:		
	Foothills Family Practice 850 East Harvard Avenue, Suite 265 Denver, Colorado 80210 P: 303.986.2274 F: 303.986.2205	**Please Fax All Requested Information To:** (303) 986-2205

Release From:	
Name/Title/Organization	
Address	
City, State & Zip	
Phone:	Fax:

The information you may release subject to this signed release form is as follows:

☐ Complete Record	☐ Lab/Radiology Reports	☐ Progress Notes
☐ Operative Reports	☐ History and Physical	☐ Psychological Notes

X _____
Initial Here

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infections, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records.

SIGN HERE →

_____ / _____ / _____

Signature of Patient, Legal Guardian or Authorized Representative

Date (mm/dd/yyyy)