Authorization for Release of Medical Records

Patient Information

Last	First	M.I.	Date of Birth
			/ /

By signing this form, I authorize Foothills Family Practice 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.

In Accordance with Colorado State Law, a fee may be charged to process this request.

Release From:		Action Requested:
	Foothills Family Practice 850 East Harvard Avenue, Suite 265 Denver, Colorado 80210 P: 303.986.2274 F: 303.986.2205	☐ Inspection of Record ☐ Copy of Record ☐ Transfer of Record --- ☐ I will pick my own records up ☐ I authorize _____ to pick up ☐ Please mail my records.

Release To:	
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

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)

Authorization Received: _____/_____/_____ | Request Completed: _____/_____/_____

By: _____ Drivers License/ID # Verification: _____ Picked Up By: _____