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### RELEASE OF MEDICAL RECORD AUTHORIZATION FORM

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
DOB: \_\_\_\_\_

#### RELEASE RECORDS TO:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

#### RELEASE RECORDS FROM:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

#### CHECK ALL THAT APPLY

- X-ray Reports     Progress Notes     Hospital Reports     Laboratory Reports
- DEXA Reports     Medication Record     Entire Record
- Other \_\_\_\_\_

#### Delivery Method:

Pick-Up     Call once records are ready for Pick-up     Mail records     Fax \_\_\_\_\_

I authorize \_\_\_\_\_ to pick up my medical records  
Name

I authorize the above facility to release the information specified only to the written named organization or physician listed. I understand that the information to be released may include sensitive information regarding specific conditions or diagnoses.

In compliance with Colorado Statute charges and fees will be applied for the release of medical information. I will pay a fee of \$14.00 for the first 10 pages, \$.50 per page for 11-40, and \$.33 for every additional page. Additional postage and shipping charges may also apply.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date of Release

If the patient is a minor, deceased or subject to legal guardianship and you have consent to sign on the patients behalf:

\_\_\_\_\_  
Legal Guardian's Signature

\_\_\_\_\_  
Legal Guardian's Printed Name

Medical Practice(s): Information obtained through medical practices is privileged and confidential. Medical records should not be disclosed to person(s) without a separate written authorization from the patient.