Aspire Family Medicine
9620 E Arapahoe Rd – Greenwood Village, CO 80112 Phone: (303) 835-9915 Fax: (303) 320-5399
Offices of Dr. Benjamin Schnurr, DO and Stella Macumber, FNP-C

Authorization To Disclose Or Release Medical Information Or Record

You must answer all questions to complete this request.

Patient Information (PLEASE PRINT LEGIBLY)

First Name:_____ MI:_____ Last Name:_____

Date of birth:_____

I, the above named patient or the parent/guardian of the above named patient, am requesting the following records *(check all that apply)*:

☐ Complete Medical Record ☐ Physician notes ☐ Immunization Record ☐ Laboratory Reports
☐ Radiology Reports ☐ Other:_____

Dates of service I am requesting records: ☐ Date range of _____/_____/_____ to _____/_____/_____
☐ I request records for all available dates MM DD YYYY MM DD YYYY

Purpose of release (***check all that apply***):☐ Personal/my request ☐ Transfer of care ☐ Other:_____

The Practice/Clinic/Hospital/Doctor/Provider I am requesting records FROM:
(Please complete all the below information)

Name:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Phone:_____ Fax:_____

☐ Check this box if you are requesting records from:

South Denver Primary Care, PC

The Practice/Clinic/Hospital/Doctor/Provider/Person I am requesting records BE RELEASED TO:
(Please complete all the below information)

Name:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Phone:_____ Fax:_____

☐ Check this box if want your records sent to:

Aspire Family Medicine
9620 E Arapahoe Rd
Greenwood Village, CO 80112
Fax: (303) 320-5399

I request and authorize the release of information to the organization or individual named above. I understand that the information to be released may include the following conditions(s): a)Drug abuse/Alcohol Abuse, b)psychiatric conditions, c) test for the presence of antibodies (HIV), d)AIDS condition, e)any third party source (hospital, specialist, lab). I understand that I have the right to revoke this authorization at any time before my records are transferred. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the office. I certify that this request has been made voluntarily. I also understand that if at my request this office releases copies of my health record directly TO ME, I am responsible for the protection of the information given to me and that privacy laws may no longer protect it. This release is valid for ONE YEAR from the date below unless revoked in writing.

_____ _____
Signature of patient or legally authorized individual **Date**

_____
Printed name of individual who signed above