ROCKY MOUNTAIN SPINE AND SPORTS MEDICINE ASSOCIATES, LLC
ROCK NAVARKAL, M.D., J.D.

Mail or Fax Medical Records to:
Rocky Mountain Spine & Sports Medicine Associates, LLC
650 S. Cherry Street, Suite 1015
Denver, CO 80246

Phone: 303-377-7777
Fax: 303-377-7775

I authorize the release of medical records and other information specified below regarding:

Full Name: _____ D.O.B.: _____

to Rocky Mountain Spine & Sports Medicine Associates, LLC / Rock Navarkal, M.D., J.D., for the purpose of medical care. The following medical information is the subject of this authorization –

Hospital or Medical provider currently holding my medical records:

_____

_____

_____

_____

_X_ Photo copies of all my history and physicals, patient intake form(s), patient recheck form(s), progress note(s), procedure / operative note(s), prescription record(s), laboratory record(s), and radiology record(s). , including all psychiatric, substance abuse, and HIV / AIDS records.

In addition to medical records, please release the following additional information with this release:

_____

_____

Please exclude the following medical records information from this release:

_____

_____

This authorization is valid until expiration on _____ or maximum of one year from the dated signature below.

_____ _____
Patient or Patient's Legal Representative Date

_____ _____
Witness (optional) Date