Lone Tree
OB/GYN & Midwives
A member of OB/GYN Affiliates

10465 Park Meadows Drive ~ Suite 104 ~ Lone Tree, CO 80124
Ph. 303.799.7903 ~ Fax 303.799.1222

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth:_____

Medical Records will be sent via fax unless otherwise requested:

Release Information TO:	Release Information FROM:
Name:_____	Name:_____
Address:_____	Address:_____
_____	_____
Phone:_____	Phone:_____
Fax:_____	Fax:_____

MY AUTHORIZATION

I hereby authorize the release of information regarding my care, including information regarding:

_____ ALL Health information related to my care and treatment.

OR (check all that apply)

_____Health information related to the following treatment or condition:_____

_____Health information for the following date:_____

_____Other:_____

_____Include or _____Exclude Health information related to drug abuse.

_____Include or _____Exclude Health information related to alcohol abuse.

_____Include or _____Exclude Health information related to HIV/AIDS

_____Include or _____Exclude Health information related to psychological or psychiatric conditions including psychotherapy notes.

Reason(s) for this authorization (check all that apply):

_____Continuation of Care _____Transfer of Care _____Other (specify):_____

MY RIGHTS

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____

_____Signature of Patient or legally authorized individual Date

Time

_____ _____

_____

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Printed Name

Relationship (self, parent, legal guardian, personal representative, etc.)