FAMILY CARE SOUTHWEST, P.C.

6169 S Balsam Way #250
Littleton, CO 80123

Office: 303-933-4555
Fax: 303-933-8147

Authorization to Request/Release Medical Records

Patient's Name: (Please Print) _____

Patient's Date of Birth: _____ Records Transmitted via _____ CD _____ Paper

_____ Medical Records **Sent To:** Family Care Southwest

_____ Medical Records **Requested From**: _____
Name

_____
Address City State Zip Code Telephone Number

OR

_____ Medical Records **Sent To:** _____
Name

_____
Address City State Zip Code Telephone Number

_____ Medical Records **Requested From:** Family Care Southwest

I authorize the release of the information specified below to the office listed above. I **specifically** authorize the release of information regarding the following condition(s): (Please initial)

_____ Drug abuse, if any
_____ Substance Abuse, if any
_____ Psychological/Psychiatric conditions, if any
_____ AIDs/HIV, if any

I authorize the release of these records: (Please initial)

_____ All Medical Records at this facility
_____ Specific Form (ie FMLA, STD/LTD paperwork -Name of form: _____
_____ Only some portions of records maintain at this facility

If you only authorize a portion of your medical record to be released, please specify below which portion you are authorizing to be released:

_____

_____

I understand this authorization will expire, with my express revocation, **<u>one year</u>** from the date of signature. I understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken based this authorization. I accept full responsibility for any copying fees.

_____ _____
Patient's Signature Date

Person Authorized to Sign for Patient (ie Parent/Guardian, MPOA, etc.)

Person's Name: (please print) _____

Person's Signature: _____

Relationship to the Patient: _____

Today's Date: _____