

PLEASE SEND TO YOUR PRIMARY CARE PHYSICIAN

NORTHERN COLORADO SURGICAL ASSOCIATES, P.C.

2121 EAST HARMONY ROAD, STE 250

FORT COLLINS, CO 80528

PHONE: 970-482-6456 FAX: 970-482-3921

MEDICAL RECORDS REQUEST & RELEASE FORM

I, _____ Patient DOB _____
Previous name: _____

Authorize you to release the following information: (Please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Complete Medical Records | <input type="checkbox"/> Pathology/Operative/Procedure Notes |
| <input type="checkbox"/> Office Visit/Progress Notes | <input type="checkbox"/> AIDS/HIV Information |
| <input type="checkbox"/> Lab Results | <input type="checkbox"/> Alcohol and/or drug abuse information |
| <input type="checkbox"/> X-RAY/Imaging reports | <input type="checkbox"/> Mental Health information |
| <input type="checkbox"/> OTHER: _____ | |

Reason for the request: Moving out of area Changing doctor Insurance
Other _____

This authorization ends:

Specify date _____

When the following event occurs _____

RELEASE MEDICAL RECORDS FROM:

Doctor/Hospital/Other facility: _____

Address: _____

City/State/Zip: _____

Phone number: _____ Fax number: _____

RELEASE MEDICAL RECORDS TO:

Doctor/Hospital/Other Facility: _____

Address: _____

City/State/Zip: _____

Phone number: _____ Fax number: _____

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

Printed name if signed on behalf of the patient **Relationship to patient**