



A Higher Level Of Quality Care

BOULDER 1155 Alpine Avenue, Ste 180 Boulder, CO 80304 - P (303) 444-9000 F (303) 444-9073
BROOMFIELD 16677 Lowell Boulevard Broomfield, CO 80023 - P (303) 938-3484 F (303) 665-1443
LAFAYETTE 300 Exempla Circle, Ste 250 Lafayette, CO 80026 - P (303) 776-9400 F (303) 682-2952
LONGMONT 2030 Mountain View, Ste 420 Longmont, CO 80501 - P (303) 776-9400 F (303) 682-2952
LOUISVILLE 90 Health Park Drive, Ste 340 Louisville, CO 80027 - P (303) 666-4343 F (303) 666-6741

AUTHORIZATION TO REQUEST/RELEASE MEDICAL INFORMATION

PATIENT (please print) _____

BIRTHDATE _____

INFORMATION AUTHORIZED FOR RELEASE: (please initial)

ALL RECORDS LAB RESULTS PATHOLOGY RESULTS
HIV TESTING OB/GYN RECORDS OTHER

REQUEST FROM: (Print name & address of Doctor or Health care facility)

RELEASE RECORDS TO:

(Print name & address of Individual, Doctor or Health care facility to whom records are to be released to)

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time except to the extent that action has already been taken to comply with it. I understand that unless specified below this consent will expire 180 days from the date of signature. I hereby release the health care provider from any liability, which may result from furnishing the information requested as authorized in this release. The health provided cannot be responsible for misuse of this information disclosed pursuant to this release.

Date Signature of Patient Person Authorized to Sign for Patient
Address Relationship to Patient
City, State, Zip Code Phone