# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME (Last, First): _____

FORMER NAME (Last, First): _____

BIRTH DATE (dd MMM yy): _____

SSN: - -

CURRENT ADDRESS: _____

City, State, Zip _____

PHONE: ( ) -

**THIS REQUEST AND AUTHORIZATION REFERS TO**:

☐ Health care information relating to the following treatment, condition, or dates of treatment: _____

☐ All health care information

☐ Other: _____

**REASON FOR RELEASE**: _____

| | **MEDICAL RECORDS FROM:** | **MEDICAL RECORDS TO:** |
|---|---|---|
| Dr or clinic name: | A Woman's Place, PC | |
| Address: | 2620 E Prospect St - Suite 160 | |
| City, State, Zip: | Fort Collins CO 80525 | |
| Phone #: | (970) 221-4977 | |
| Fax #: | (970) 221-4980 | |

I understand that these records may contain information regarding the diagnosis or treatment of HIV (AIDS Virus), other sexually transmitted diseases, drug and/or alcohol abuse and/or treatment, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. I understand that this request for release is effective for 90 days. SIGNATURE OF THE PATIENT IS REQUIRED OF ALL PATIENTS 18 YEARS OF AGE OR OLDER. PARENT OR LEGAL GUARDIAN MAY PROVIDE AUTHORIZING SIGNATURE IF THE PATIENT IS A MINOR.

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE SIGNED

_____ _____

WITNESS DATE SIGNED

There is a charge for copies of records from A Woman's Place. Information in the records is the patient's property. The medical record itself is the physician's property.
FEE SCHEDULE (established by the Colorado Medical Society: $14 FOR THE FIRST 10 PAGES, $0.33 FOR EACH ADDITIONAL PAGE THEREAFTER.