FAMILY CARE
SOUTHWEST, P.C.

AUTHORIZATION TO RELEASE MEDICAL RECORDS TO FAMILY CARE SOUTHWEST P.C.

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

Records Request From:

Doctor: _____
Address: _____
_____
Fax and phone # _____

Sent To:
Family Care Southwest P.C.
6169 S Balsam Way, #250
Littleton CO, 80123

Patient's Name: _____ Phone #_____
Date of Birth: _____

I authorize the health care provider to release the information specified below to Family Care Southwest P.C. I specifically authorize the release of information regarding the following condition(s):

Initials
_____ Drug Abuse If Any
_____ Psychological/Psychiatric Conditions if Any

Initials
_____ Substance Abuse If Any
_____ AIDS/HIV If Any

Release These Records:

Initials
1. All Medical records at this facility _____

2. Only records generated by this facility (not Including records from other sources)

3. Only some portions of records Maintained at facility (specify below).

_____

_____

I understand this authorization will expire, with my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I accept full financial responsibility for copying fee.

Patient Name (Print)

_____

Patient's Signature

_____

Date

Person Authorized to Sign for Patient:

_____

Signature

_____

Relationship to Patient Date