Critical Care & Pulmonary Consultants
5200 DTC Parkway
Greenwood Village, CO 80111
Phone # 303-745-0000 Receptionist Fax # 303-773-3675

Authorization to Release Medical Records/Information

Physician or facility to provide records: _____

Patient's name: _____

Social Security No.: _____ DOB: _____

Person to receive records (name and address):

_____

_____

I authorize the health care provider to release the information specified below to the organization, agency, or individual named on this request. I specifically authorize the release of information regarding the following condition(s):

Initials		Initials	
_____	Drug abuse, if any	_____	Substance abuse, if any
_____	Psychological or psychiatric conditions, if any	_____	AIDS/HIV, if any

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Release these records: Initials

1. Only records generated by this facility (not including records received from other sources) _____
2. Only some portion of records maintained at facility (specify below) _____
3. All medical records at this facility _____

_____

_____

_____

Expiration or revocation of authorization—I understand that I may revoke this authorization at any time.
Use of copies — A copy of this authorization may be utilized with the same effectiveness as an original.

_____	_____
Patient Name (Print)	Person authorized to sign for patient (Print)
_____	_____
Patient signature	Signature
	_____
	Relationship to Patient
_____	_____
Date	Date