

Authorization To Disclose Or Release Medical Information Or Record

You must answer all questions to complete this request.

Patient Information (PLEASE PRINT LEGIBLY)

➔ First Name: _____ MI: _____ Last Name: _____

➔ Date of birth: _____

I, the above named patient or the parent/guardian of the above named patient, am requesting the following records (*check all that apply*):

➔ Complete Medical Record Immunization Record Laboratory Reports
 Radiology Reports Other: _____

➔ Dates of service I am requesting records: Date range of ____/____/____ to ____/____/____
 I request records for all available dates
MM DD YYYY MM DD YYYY

➔ Purpose of release (*check all that apply*): Personal/my request Transfer of care Other: _____

The Practice/Clinic/Hospital/Doctor/Provider I am requesting records **FROM:**
(Please complete all the below information)

➔ Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

Check this box if you are requesting records from:
Denver Travel Medicine Clinic, PC

The Practice/Clinic/Hospital/Doctor/Provider/Person I am requesting records **BE RELEASED TO:**
(Please complete all the below information)

➔ Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

Check this box if want your records sent to:
Denver Travel Medicine Clinic, PC
9620 E Arapahoe Rd
Greenwood Village, CO 80112
Fax: (303) 320-5399

I request and authorize the release of information to the organization or individual named above. I understand that the information to be released may include the following conditions(s): a) Drug abuse/Alcohol Abuse, b) psychiatric conditions, c) test for the presence of antibodies (HIV), d) AIDS condition, e) any third party source (hospital, specialist, lab). I understand that I have the right to revoke this authorization at any time before my records are transferred. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the office. I certify that this request has been made voluntarily. I also understand that if at my request this office releases copies of my health record directly TO ME, I am responsible for the protection of the information given to me and that privacy laws may no longer protect it. This release is valid for ONE YEAR from the date below unless revoked in writing.

➔ _____
Signature of patient or legally authorized individual

➔ _____
Date

➔ _____
Printed name of individual who signed above