Authorization to Release Medical Records/Information

Patient Name: ______________________________ Date of Birth: ______________

Address: ______________________________ City/State: ______________

ZIP Code: __________ Phone: ______________ Last 4 Digit Social Security: ________

To disclose/release the following information *(check all that apply):

- ☐ All Records
- ☐ Office Notes (previous 3 years)
- ☐ Labs/pathology (previous 3 years)
- ☐ Most Recent
- ☐ Radiology Records (previous 3 years)
- ☐ Other ______________

Requesting records from:

Name/Doctor: ______________________________ Phone: ______________

Fax: ______________ Address: ______________________________

City/State: ______________________________ ZIP Code: ______________

Please send the records to:

☐ Advanced Heart and Vein Center 805 E. 144th Ave. Suite 100 Thornton, CO 80023
P) 720-772-8040
F) 720-805-1551

☐ Name/Doctor: ______________
Address: ______________
City/State: ______________
Phone: ______________
Fax: ______________

☐ Self

Release Medical Information generated only by this facility:

I specifically authorize the release of information regarding the following condition(s): Please check below all that apply

☐ Psychological or psychiatric conditions if any ☐ Substance abuse if any ☐ Drug abuse if any ☐ AIDS/HIV if any

I understand that I may revoke this authorization at any time. This authorization will expire in 1 year from date signed, unless revoked. A copy of this authorization may be utilized with the same effectiveness as an original.

____
Person authorized to sign for patient (Please Print) POA

____
Patient Name (Please print)

______________________ ______________
Signature Date

______________________ ______________
Patient's signature Date

____
Relationship to patient