

**Alpine
Women's
Healthcare, P.C.**

Obstetrics • Gynecology • Incontinence

499 E. Hampden Ave., Suite 350 • Englewood, Colorado 80113
(303) 744-3477 FAX (303) 733-5848

Authorization to Release Medical Records / Information

Physician or facility to provide records: _____

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):

<u>Initials</u>	<u>Initials</u>
_____ Drug abuse if any	_____ Substance abuse if any
_____ Psychological or psychiatric conditions if any	_____ AIDS / HIV if any

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): _____ DOB: _____

Patient's signature: _____ Date: _____