Fort Collins Primary Care, PLLC
1006 Robertson St. Fort Collins, Colorado 80524
Phone: 970-484-9027 Fax: 970-482-4942

Patient Information:

Patient Name (PRINT) _____ Date of Birth _____

Street Address _____ Phone Number _____

City, State, Zip Code _____

Release Medical Records From:

☐ Fort Collins Primary Care

or

Doctor/Hospital _____

Street Address _____

City, State, Zip Code _____

Phone Number _____ Fax Number _____

Release Medical Records To:

☐ Fort Collins Primary Care

or

Name of Company/ Agency/ Facility/ Person/ Medical Provider _____

Street Address _____

City, State, Zip Code _____

Phone Number _____ Fax Number _____

Information to be released:

___ I do ___ I do not authorize the release of information related to HIV/AIDS, psychological or psychiatric conditions, and treatment
for alcohol and/or drug abuse.
Release the following records:

___ 2yrs medical records including progress notes and diagnostic results

___ Only some portion of the records (please specify):_____

___ Other (please specify):_____

Purpose of Disclosure:

_____Referral to Specialist _____Permanent Transfer _____Personal _____Insurance

_____Workers Comp _____Legal Investigation _____Disability Determination _____Other

There will be a charge for a copy of your records. The fee is 1-40 pages at .50 ea, 41-100 at .33 ea, 101+ at .15 ea.

This authorization is valid for 1 year from date of signature unless otherwise indicated:_____

Patient Rights: I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment) However, I do have to sign an authorization form: To take part in a study or to receive health care when the purpose is to create health information for a third party, I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may write a letter to the office to revoke this authorization. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient Signature or legally authorized individual _____ Date _____