Alpine Surgical
4745 Arapahoe Avenue Suite 300
Boulder CO 80303
www.alpinesurgical.net
Phone 303.449.3642 Fax 303.440.7298

Authorization to Release Medical Records/Information

Patient Name: ___________________________________

Social Security Number: ______ - _____- ______ Date Of Birth: __________________________

Release Records/Information **FROM**: (Check One)

☐ Alpine Surgical/Dr Richard Fox
4745 Arapahoe Ave Suite 300
Boulder, CO 80303
Phone: 303-449-3642
Fax: 303-440-7298

☐ Name: ____
Address: ______________________________________
City/St/Zip: ____________________________________
Phone: ____
Fax: ____

I authorize the above named organization, agency, or individual to release the information annotated by my initials below to the organization, agency, or individual named below on this request.

Release Records/Information **TO**: (Check One)

☐ Alpine Surgical/Dr Richard Fox
4745 Arapahoe Ave Suite 300
Boulder, CO 80303
Phone: 303-449-3642
Fax: 303-440-7298

☐ Name: ____
Address: ______________________________________
City/St/Zip: ____________________________________
Phone: ____
Fax: ____

Release Records: *Initials:*

Only Records generated by this facility (not including records received from other sources)………………….. ______

Only Records from a specific date or regarding a specific condition (specify below)……………………………… ______

____

____

All Medical Records contained at this facility……………………………………………………………………………………. ______

I authorize release of records related to or containing information regarding:

Initials: *Initials:*

Drug Abuse, if any ………………… ______ Psychological or psychiatric conditions, if any……………… ______

Substance Abuse, if any………… _______ AIDS/HIV or other STD's……………………………………………… ______

I understand that I may revoke this authorization at any time. A copy of this authorization may be used with the same effectiveness as the original.

____ _______________________________________

Patient or Authorized Signature Date Name of person authorized to sign for patient

____ _______________________________________

Staff/Witness Signature Date Relationship to Patient