ALPINE SURGICAL
Dedication Above and Beyond.

Anderson Medical Center
4743 Arapahoe Avenue, Suite 102
Boulder, CO 80303
www.boulderveins.com
Phone 303.449.3642 Fax 303.440.7298

Authorization to Release Medical Records/Information

Patient Name: _____ Date of Birth: _____

Social Security Number: _____

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

☐ Alpine Surgical
4743 Arapahoe Ave Suite 102
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
4743 Arapahoe Ave Suite 102
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