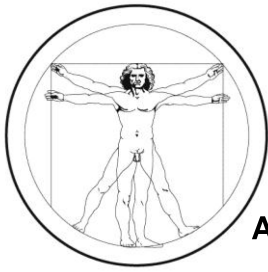

Platte River Medical Clinic
Family Care and Women's Health

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print):
Name: ____
Date of Birth:_______________________________SS#:________________________________
Address:____
City:__________________________________ State:_______________ Zip Code:______________
Home Phone:___________________________Cell/Work/Other:__________________________

RELEASE MOST RECENT PHYSICAL EXAM FINDINGS INCLUDING: Medications and Complete Problem List, Labs, Pathology, EKG, PAP and Mammogram reports. If a child, please include complete immunization history.
SPECIFIC RECORDS ONLY:____
____

Release my medical records **FROM**:

Name:____
Phone:____
Fax:____

TO:
Platte River Medical Clinic
Tony G. Euser, D.O.; Sepeideh Nouhi, M.D.
Shannon Ballard, PA-C; Erin Keefer, PA-C;
Shawna Morgan, PA-C; Lisa Whittaker, PA-C
36 S. 18th Ave. Suite B
Brighton, CO 80601
(p) 303.659.7600 (f) 303.558.8223

I understand that my medical records are protected under State and Federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections, including testing and treatment for HIV/AIDS, and diagnosis of mental illness or psychiatric care cannot be released without my written consent. Please initial the line below if you DO NOT want any of the following records to be released. All applicable records will be released if nothing is marked or noted.

________ Drug and/or alcohol abuse, diagnosis or treatment
________ HIV/AIDS testing and/or treatment
________ Psychiatric care and/or mental illness
________ Confirmed STD test results and/or treatment

Please release a copy of all medical records.
This release will be valid for 1 year from the date of signature.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS.

__________________________/____________________________/__________________
Patient Signature | Printed Signature | Date