



Colorado Cardiovascular Center
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MEDICAL RECORDS RELEASE

RECORDS RELEASED FROM:
 PHYSICIANS OFFICE OR FACILITY ADDRESS:

RECORDS RELEASED TO:
 PHYSICIANS OFFICE OR FACILITY ADDRESS:

I hereby authorize you to furnish a copy of my medical records covering the period from _____ to _____, **(ALL)**, or allow those records to be inspected or copied by Colorado Cardiovascular Center, L.L.C. or, MYSELF. I release you from all legal responsibility or liability that may arise from the authorization.

PATIENT INFORMATION:

NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____

PHONE NUMBER: _____

I understand that the information to be released includes information regarding the following condition (s). Check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Alcoholism or alcohol abuse |
| <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Psychological/Psychiatric consent. |
| <input type="checkbox"/> Human Immunodeficiency Virus (HIV) | |

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already taken place to comply. (Redisclosure of my medical record by those receiving the above-authorized information may not be accomplished without my further written consent) .

 Witness Date

 Signature/ Date (patient if at least 18 years of age:
 Parent or Guardian if minor