AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

Physician or facility to provide records: _____

Patient's name: _____

Address: _____

Social Security #: _____ DOB: _____

Records to be received by: DO NOT FAX RECORDS

Potomac Primary Care
1400 South Potomac Street #190
Aurora, CO 80012
Phone 720-979-0836
Fax 303-369-1919

I authorize the health care provider to release the information specified below to the organization, agency, or individual named on this request. I specifically authorize the release of information regarding the following condition(s):

_____Drug Abuse (if any) Substance Abuse (if any) _____

_____Psychological or psychiatric conditions (if any) AIDS/HIV status (if any) _____

Release these records:

1. Only records generated by this facility (not including records received from other sources) _____
2. Only some portion of records maintained at facility (specify below) _____
3. All medical records at this facility _____

Expiration or revocation of authorization: I understand that I may revoke this authorization at any time.

Use of copies: A copy of this authorization may be utilized with the same effectiveness as an original.

Patient name (print): Person authorized to sign for patient:

_____ _____

Patient's signature:

_____ Date: _____