Anderson Medical Center
4743 Arapahoe Avenue, Suite 102
Boulder, CO 80303

Avista Medical Office Building
80 Health Park Drive, Suite 250
Louisville, CO 80027

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
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