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

www.alpinesurgical.net
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