

## **Records Release Authorization**

3150 N. 12<sup>th</sup> Street • Grand Junction, Colorado 81506 P.O. Box 10700 • Grand Junction, Colorado 81502

* FAXED OR MAILED RECORDS RELE	ASE SHOULD BE ACCOMPAN	NIED BY PICTURE	E ID (OR THAT OF A PARENT	/GUARDIAN) & WITNE	SS SIGNATURE *
I give permission to Primary Care Partners to: (check <u>one</u> )			Name		
□ Obtain (get) information		Address			
☐ Release (give) information					
☐ Exchange (share) information		Phone	Fax	Fax	
This authorizes the release of the requested information on the individual(s) below: (One patient per line. If additional space is needed, please use back of form)					
Patient Name			DOB		
Patient Name			DOB		
Information Format:	□ Mail	☐ Pick up	□ Fax	□ Email	☐ USB drive
Information Requested:					
<ul> <li>□ Standard Records (last 3 yrs. office visits, physicals, growth chart, vaccines, problem list, laboratory results, radiology reports, hospital notes)</li> <li>□ Limited Records (event, dates:)</li> <li>□ Complete Records</li> </ul>					
□ Immunization Records					
□ Psychotherapy Notes					
□ Radiology Images (date:) Primary Care Partners can only provide images for tests we have conducted. For radiology done by a third party, please request the images directly from them.					
I request and authorize the above named provider/s to release this information. I understand the records may include information regarding the following conditions: drug or alcohol abuse, psychological or psychiatric conditions, developmental disabilities, HIV, AIDS, sexually transmitted diseases, pregnancy or other sensitive information. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment, my eligibility for benefits, etc. will not depend in any way on whether I sign this authorization or not. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. This authorization will expire 1 year from the date below.					
First copies are at no charge. I understand that I may be charged a reasonable fee per rates set by the Colorado State Board Health after the first courtesy release for: paper copies or transfer, electronic records, or mailing (includes postage/materials).  □ I hereby agree to pay the charges specified above. Please bill me. □ Please contact me with total incurred cost					
Print Name Relationship to Patient					
Signature	Date				
Witness Signature Date					

PCP Care Village 3150 N 12<sup>th</sup> Street Grand Junction, CO 81506

Western Colorado Pediatrics 970-243-5437 Family Physicians of Western Colorado 970-245-1220

Tabeguache Family & Sports Medicine 970-256-5201 Diagnostics & Mammography 970-241-6014 Physical Therapy Specialty Center 970-241-5856 Nutrition Therapy & Wellness 970-255-1576 After-Hours Clinic 3150 N 12th Street Grand Junction, CO 81506

DOCS on Call 970-255-1576

Wellington Location 1120 Wellington Ave Grand Junction, CO 81501

Western Colorado Physicians Group 970-241-6011 Fruita Location 455-456 Kokopelli Blvd Fruita, CO 81521

Western Colorado Pediatrics 970-243-5437

Red Canyon Family Medicine 970-256-5285