AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME: ______________________________

DATE OF BIRTH: ______________________________

ADDRESS: ______________________________

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PHONE: ______________________________

Please release medical records and information from: (check one)

☐ Westminster Medical Clinic
8601 Turnpike Drive, Suite 200
Westminster, CO 80031
Phone: (303) 428-7449
Fax : (303) 487-5196

☐ Name: ______________________
Address: ______________________
____
Phone: ______________________
Fax: ______________________

Please include the following information: (select all applicable)

☐ Most recent 3 years of record
☐ Entire medical record
☐ Other: ______________________
☐ Lab results
☐ Imaging (including x-ray, MRI, CT, etc.)

Please send the medical records and information listed above to: (check one)

☐ Westminster Medical Clinic
8601 Turnpike Drive, Suite 200
Westminster, CO 80031
Phone: (303) 428-7449
Fax : (303) 487-5196

☐ Name: ______________________
Address: ______________________
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Phone: ______________________
Fax: ______________________

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1. I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse, sexually transmitted diseases (STDs) and past medical history.
2. I understand this authorization will expire upon completion of this request or on the future date listed here: _______________. If no future date is listed, this authorization will expire upon completion of this request. I understand that I may withdraw this authorization in writing at any time except to the extent that action has been taken based on it. I understand that withdrawing this authorization will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.
3. I authorize Westminster Medical Clinic to provide the above requested information on a compact disc (CD) in portable document format (PDF) unless otherwise specified. I accept full financial responsibility for copying fees:
   a. CD: The fee for electronically copying requested documents is $10.
   b. PRINT: Per Colorado Department of Public Health and Environment Regulations, the fee for copying requested documents is $14.00 for the first ten pages, $0.50 per page for pages 11 through 40 and $0.33 per page for each page over 40.

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Signature of patient or personal representative   Date

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Personal representative's name (please print)   Relationship to patient