Rocky Ford Family Health Center

## Authorization to Release Medical Records/Information

**Provider to send records: Rocky Ford Family Health Center**
**1014 Elm Avenue**
**Rocky Ford, CO 81067**
**Phone #: (719) 254-7421 Fax #: (719) 254-6966**

**Provider to receive records:**

Name:_______________________________________
Phone #:________________________________
Fax #:_________________________________

**Patient Name:__________________________________________**

**Social Security Number:__ __ __ - __ __ - __ __ __ __ DOB:___________________**

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

**Initial Please:**
_____**Drug abuse if any**
_____**Psychological or psychiatric conditions if any**

**Initial Please:**
_____**Substance abuse** if any
_____**AIDS/HIV if any**

| **Release these records:** | **Initial Please:** | **Comments:** |
|---|---|---|
| **1. All records generated by this facility** | __________ | __________ |
| **2. Only Some portion of records generated by this facility (Please Specify)** | __________ | __________ |

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 (please print)** **OR** **Person authorization to sign for patient**

| | |
|---|---|
| ______________________ | ______________________ |
| Address | Address |
| ______________________ | ______________________ |
| Signature | Signature |
| ______________________ | ______________________ |
| Date | Date |
| ______________________ | ______________________ |