Rocky Ford Family Health Center

Authorization to Release Medical Records/Information

Provider to provide records:

Name:_____

Phone #:_____

Fax #:_____

Patient Name:_____

Social Security Number:___ ___ ___ - ___ ___ - ___ ___ ___ ___ **DOB:**_____

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

I authorize the "provider to provide records" to release the information specified below to the "provider to receive records". 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**

_____ _____
Name Name

_____ _____

_____ _____
Address Address

_____ _____
Signature Signature

_____ _____
Date Date