

Western Valley Family Practice

Redlands After Hours

281 N. Plum Fruita, Colorado 81521

2237 Redlands Parkway Grand Junction, Colorado 81507

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FAXED OR EMAILED RECORDS RELEASES MUST BE ACCOMPANIED BY PARENT OR GUARDIAN PICTURE ID AND WITNESS FULL SIGNATURE, ADDRESS, AND PHONE NUMBER

Consent to Release Information Via: **Secure Fax** (to another Medical Provider only)

Mail **Pick Up Date** _____ (Allow 30 Working Days)

I authorize:

Name:

Address:

Phone:

Fax:

To release to:

Name:

Address:

Phone:

Fax:

This form authorizes the release of the requested information on the below named patient:

(One patient per form please)

Patient Name:

Date of Birth:

Information Requested:

- Standard Records (last 3 years office visits, physicals, vaccines, labs, hospital notes)
- Records for specialist referral
- Limited Records (event, dates: _____)
- Immunization Records

Reason(s):

- Referral Other _____
- Consult _____
- Moving _____
- Changing Doctors _____
- Insurance _____

****Your request will be processed and fulfilled within 30 business days. Listed below are the charges for copying records. There is no charge for doctor to doctor requests.**

Medical Records Flat Fee (Pages 1-10) \$16.50

Additional Pages # 11-40 (cost per page) \$0.75

Additional Pages # 41 + (cost per page) \$0.50

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 expires 120 days from the signed date below. A copy of this authorization will serve as a valid original.

Print Name

Relationship to Patient

Signature

Phone Number

Date

Witness Signature

Date