**REQUEST TO RELEASE MEDICAL RECORDS**

**SOUTHWEST INTERNAL MEDICINE**
**111 NORTH PARK**
**CORTEZ, CO 81321**
**PHONE (970) 564-8730**
**FAX (970) 565-5430**

**KARLA DEMBY, MD ANDREW MCALPIN, MD ERIN HENDERSON, MD**
**ROBIN RICHARD, MD**

**PATIENT NAME_____DOB_____**

**I AUTHORIZE YOU TO PROVIDE RECORDS TO:**

_____
**Physician's or Facility Name**

_____
**Address**

_____
**City State Zip**

**Release the following Records**

**___ All Records in your possession**
**___ Treatment Related to _____**
**___ Only Records Generated by this Facility**
**___Other:_____**

**Please Initial**
**I specifically authorize the release of information regarding the following conditions if any exist in my chart:**

> **____ Drug abuse** > **____Psychiatric condition**
> **____ Substance abuse** > **____AIDS or HIV.**

> **____ I understand that I may revoke this authorization at any time**

> **____ A copy of this authorization may be utilized with the same effectiveness as an original.**

> _____ > _____
**PATIENT SIGNATURE** **DATE**

_____ _____
**PERSON AUTHORIZED TO SIGN FOR PATIENT** **DATE**
**RELATIONSHIP_____**