AUTHORIZATION TO RELEASE MEDICAL RECORDS

_____
Physician's or Facility Name

_____
Address

_____
City State Zip

PATIENT NAME_____DOB_____

I HEREBY REQUEST THAT MY MEDICAL RECORD BE RELEASED TO:

SOUTHWEST INTERNAL MEDICINE
111 NORTH PARK
CORTEZ, CO 81321
PHONE (970) 564-8730
FAX (888) 832-1367

ANDREW MCALPIN,MD

ERIN HENDERSON, MD ROBIN RICHARD, MD

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_____