



3744 South Timberline Road, Suite 102
Fort Collins, CO 80525
(970)495-0506 Fax: (970) 495-0485

AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

Patient Name _____

Date of Birth: _____ Phone #: _____

OBTAIN FROM: _____ (Releasing facility)

Phone#: _____ Fax#: _____

RELEASE TO: _____ (Receiving Facility)

Phone#: _____ Fax #: _____

I hereby give the releasing facility permission to disclose my individually identifiable health information as listed below, I understand that once this information is disclosed, it may no longer be protected by Front Range Pain Medicine, LLC I understand that this authorization is voluntary, that further treatment can not be conditioned upon my signing this authorization, and that there may be a cost to copy the records.

Date of service range (month/year): From: _____ To: _____

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY):

All Records__ Clinic/Progress Notes ____

Other Information: _____

PURPOSE FOR THE DISCLOSURE: To obtain medical records for pain management treatment

AUTHORIZATION: I understand that I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand that this consent will expire 180 days from the date of my signature unless I provide notice in writing that it should be revoked. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy of facsimile of this form is to be considered as valid as the original.

PATIENT'S ACKNOWLEDGEMENT OF ACCESS TO MEDICAL RECORDS

I hereby acknowledge that I the patient/authorized representative have reviewed and/or received photocopies of the medical records from the Front Range Pain Medicine, LLC for the above named patient.

Signature _____ **Date** _____

Signature of Patient Representative (required if the patient is a minor or an adult who is unable to sign this form) _____ **Date** _____

Relationship to Patient: _____