

 AUTHORIZATION TO RELEASE INFORMATION

 Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_

 Released To/From:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 I request and authorize the above named doctor or health care provider to release

 my information to the organization, agency or individual named on this request.

 PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

 \_\_\_ Transfer of records

 \_\_\_ Second Opinion

 \_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient/Guardian Signature Date

19621 Solar Circle, Ste 202 ⦁ Parker, CO ⦁ 80134 ⦁ (720) 851-1676 ⦁ hollyslettendmd@comcast.net