REQUEST FOR RELEASE OF MEDICAL RECORDS

Last Name First Name M.I. DOB

Street Address City State Zip Code

Phone Other Name(s) - if applicable

RECORDS TO BE SENT FROM:

Denver Fertility / Albrecht Women's Care
9780 Pyramid Court, Suite 260
Englewood, CO 80112
Fax: 866-657-9471 Email: info@albrechtwomenscare.com
Phone: 720-420-1570

RECORDS TO BE RELEASED TO:

Practice/Physician Name

Street Address City State Zip Code

Phone Fax

Records of care from (dates): _____ to _____

____ Complete Medical Record ____ Laboratory Reports ____Medical Imaging Reports
____ Pathology Reports ____ Surgical Records
____ Other (specify): _____

I understand by signing this release form, I give my permission to release my confidential information to the above named physician/clinic. My signature also authorizes the release of any information relating to AIDS or HIV testing, alcohol use, or mental status contained in my records. I understand I can revoke this request at any time in writing, except to the extent that action has already been taken.

Signature: _____ Date: _____

Witness: _____ Date: _____

Appointment Date and Time: _____