Surgery Center of Fort Collins

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. Initial: _____ Date: _____

information, to the person(s) or entity listed below.

Patient Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____

Limitations on the information you may release subject to this Release Form are as follows:

_____
_____
_____

Release my protected health information to the following person(s)/entity:

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____Fax:_____

The reasons or purposes for this release of information are as follows:

_____
_____

Patient Signature (or parent, guardian or legal representative):

_____ Date: _____

Authorization of Release In Effect Until:
Date: _____