**Anderson Medical Center**
4743 Arapahoe Avenue, Suite
102 Boulder, CO 80303
www.boulderveins.com
Phone 303.449.8346 Fax 303.440.7298

# Authorization to Release Medical Records/Information

Patient Name: ________________________________________________ Date of Birth: ____________________

Social Security Number: _________________________________________

Release Records/Information **FROM**: (Check One)

☐ Alpine Surgical
4743 Arapahoe Ave Suite 102
Boulder, CO 80303
Phone: 303-449-8346
Fax: 303-440-7298

☐ Name: _____________________________________
Address: _____________________________________
City/St/Zip: __________________________________
Phone: ______________________________________
Fax: ________________________________________

I authorize the above named organization, agency, or individual to release the information annotated by my initials below to the organization, agency, or individual named below on this request.

Release Records/Information **TO**: (Check One)

☐ Alpine Surgical
4743 Arapahoe Ave Suite 102
Boulder, CO 80303
Phone: 303-449-8346
Fax: 303-440-7298

☐ Name: _____________________________________
Address: _____________________________________
City/St/Zip: __________________________________
Phone: ______________________________________
Fax: ________________________________________

Release Records: *Initials:*

Only Records generated by this facility (not including records received from other sources)………………….. ______

Only Records from a specific date or regarding a specific condition (specify below)…………………………….. ______

______________________________________________________________________________

______________________________________________________________________________

All Medical Records contained at this facility………………………………………………………………………………. ______

I authorize release of records related to or containing information regarding:

| | *Initials:* | | *Initials:* |
|---|---|---|---|
| Drug Abuse, if any ………………… | ______ | Psychological or psychiatric conditions, if any……………… | ______ |
| Substance Abuse, if any………… | ______ | AIDS/HIV or other STD's……………………………………………. | ______ |

I understand that I may revoke this authorization at any time. A copy of this authorization may be used with the same effectiveness as the original.

___________________________________________ ___________________________________

Patient or Authorized Signature Date Name of person authorized to sign for patient

___________________________________________ ___________________________________

Staff/Witness Signature Date Relationship to Patient