

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Patient Name (Last, First): \_\_\_\_\_  
Former Name (Last, First): \_\_\_\_\_  
Birth Date (dd/mm/yyyy): \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Current Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

**THIS REQUEST AND AUTHORIZATION REFERS TO:**

ف Health care information relating to the following treatment, condition, or dates of treatment: \_\_\_\_\_  
ف All health care information  
ف Other : \_\_\_\_\_

REASON FOR RELEASE: \_\_\_\_\_

**MEDICAL RECORDS FROM:**

**MEDICAL RECORDS TO:**

Dr or clinic name:  
A WOMAN’S HEALING CENTER, LLC  
Address: 1006 Luke St \_\_\_\_\_  
City, State, Zip : Fort Collins, Co 80524 \_\_\_\_\_  
Phone #: 970-419-1111 \_\_\_\_\_  
Fax #: 970-407-0001 \_\_\_\_\_

I understand that these records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse and/or treatment, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. SIGNATURE OF THE PATIENT IS REQUIRED OF ALL PATIENTS 18 YEARS OF AGE OR OLDER. PARENT OR LEGAL GUARDIAN MAY PROVIDE AUTHORIZING SIGNATURE IF PATIENT IS A MINOR.

\_\_\_\_\_  
Signature of patient or authorized representative Date signed

\_\_\_\_\_  
Witness Date Signed

There is a charge for copies of records from A Woman’s Healing Center, LLC. Information in the records is the patent’s property. The medical record itself is the physician’s property.  
FEE SCHEDULE (established by the Colorado Medical Society: \$14 for the first 10 pages, \$0.25 for each additional page thereafter.