AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name (Last, First)_____
Former Name (Last, First _____
Birth Date (dd/mm/yyyy)_____
SSN _____
Current Address_____
City, State, Zip_____
Home Phone _____Cell_____Other_____

THIS REQUEST AND AUTHORIZATION REFERS TO:

ڤ Health care information relating to the following treatment, condition, or dates of treatment_____

ڤ All health care information_____

ڤ Other_____

REASON FOR RELEASE _____

MEDICAL RECORDS FROM:	**MEDICAL RECORDS TO:**
Dr. or clinic name_____	A Woman's Healing Center
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.