2685 Dublin Boulevard
Colorado Springs, CO 80918
(719) 592-9890

DUBLIN PRIMARY CARE
Authorization to Release Medical Information

______________________________ Patient Name (Please Print)

______________________________ Date of Birth

I hereby authorize:	**To release information to:**	**Patient Address:**
	DUBLIN PRIMARY CARE	
	2685 Dublin Blvd.	
	Colorado Springs, CO 80918	
	(719) 592-9890	
Phone:		
Fax:	**Provider:**	**Phone:**

Information Requested:
_______ Complete Chart

If not requesting complete chart, please indicate the information you are requesting: Circle All Applicable

Doctor's Notes	Lab Reports	Mental Illness, Psychiatric Treatment
X-Ray Reports	Immunization Records	Drug or Alcohol Abuse
HIV	Other (Please Specify)	

If only certain items are requested please specify the dates of care:___________________________________
Reason for record transfer:
_____Moving _____Change of Insurance _____Legal ______ Consult ______Other

I request and authorize ____ to release the specific information to the individual named on this request. I am aware that this information may also include my current or past residences. Any patient 18 years of age or older must sign for their own records. This form is valid for one year from the signature date. You have the right to revoke this authorization any time before the one year expiration in writing.

Signature of Patient: ____Date:__________________________

This form is being provided as a courtesy to our patients. It is the sole responsibility of the patients to obtain their medical records from previous physician offices.

Revised 2018