DUBLIN PRIMARY CARE

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:	**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 Dublin Primary Care 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. I understand that prepayment is required before my medical records will be copied and transferred. I further understand that prepayment will be required if I would like more than two years transferred to another physician. Any patient 18 years of age or older must sign for their own records. See Fee Schedule below.

Signature of Patient: _____Date:_____
This form is valid for 1 year from the signature date. You have the right to revoke your authorization at any time by contacting our office in writing.

To ensure timely processing of medical records, please fill authorization out completely.

( ) $25.00 Flat Fee for medical records to patient/parent
( ) Complementary to another physician (Last two years)

Revised 2018