DUBLIN PRIMARY CARE

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Authorization to Release Medical Information

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

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.

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.