

OB/GYN CENTER
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release my healthcare information to the following practice listed below:

Name: _____ Phone#: _____

Address: _____ Fax#: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

All healthcare information and records

Healthcare information relating to the following treatment, condition(s):

Other: _____

Unless otherwise indicated, this release will include two years prior to the date of the signature. If you desire other dates, please indicate: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 79.24 et seq, includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, BDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date signed: _____

To further help us in storing your records, please check the appropriate box:

Please purge my records as I am transferring care. Indicate the reason for transferring care:

Please keep my records current as I am still a patient in your care