PARKSIDE OBGYN & Medical Spa
7120 E. Hampden Ave., Suite A, Denver, CO 80224 (303)-758-0072 tel: (303)-758-3983 fax

Authorization to Release Medical Records/Information

Physician or facility to provide records: ____

Patient's name: ____

Social Security #: ______________________________ DOB: _________________________________

Person to receive records (name, address, phone, and fax):
( ) Parkside ObGyn & Medical Spa 7120 E. Hampden Ave., Suite A, Denver, CO 80224 (303)-758-0072 ph (303)-758-3983 fax

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( ) Other facility:
Initial choice____

I authorize the health care provider to release the information specified below to the organization, agency, or individual named on this request. I specifically authorize the release of information regarding the following condition (s):

Initials	Initials
_____ Drug abuse if any	_____ Substance abuse if any
_____ Psychological or psychiatric conditions if any	_____ AIDS/HIV if any

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Release these records: Initials

1. Only records generated by this facility (not including records received from other sources)..... ________
2. Only some portion of records maintained at facility (specify below)......................................________
3. All medical records at this facility...________

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Expiration or revocation of authorization—I understand that I may revoke this authorization at any time.
Use of copies—A copy of this authorization may be utilized with the same effectiveness as an original.

Patient name (print):	Person authorized to sign for patient: (print)
______________________________	______________________________
Patient's signature:	Signature:
______________________________	______________________________
Date:	Relationship to patient:
______________________________	______________________________