130 Rampart Way
Suite 150
Denver, CO 80230
(303) 344-3625

Lisa Davidson D.O.
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Fax: (303) 360-8575

Patient Name: ______________________ Date of Birth: ________________

Social Security #: ____________________ Phone Number: ________________

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I authorizie the following facility:

Family Medicine at Lowry
130 Rampart Way #150
Denver, CO 80230

To release information to:

____
____
____

Records will be mailed directly to the person or organization specified above.

Information requested (check if to be released):

- ☐ Complete Chart
- ☐ Pathology Reports
- ☐ Doctors Notes
- ☐ History and Physical
- ☐ Treatment Dates
- ☐ Other (must specify)
- ☐ Diagnostic Studies
- ☐ Operative Reports
- ☐ Lab/X-Ray Reports
- ☐ Psychological/Psychiatric

Specific Dates: ______________________________

Other (must specify) ______________________________

Purpose of Release: ☐ Treatment/Diagnosis ☐ Insurance ☐ Legal ☐ Other: __________

This authorization is subject to written revocation at any time, except to the extent that action has already been taken in reliance upon it. In any event, this authorization expires 90 days from the date of signature. I release the above named facility and it employees or agents from liability and claims of any nature pertaining to the disclosure of requested information contained in my medical records.

______________________________ ______________ ____________
Signature of Patient/Guardian/Personal Representative Relationship Date

______________________________ ______________
Witness Signature (if patient is unable to document for any reason) Date

Note: Information requested will NOT be provided if any of the above items have not been completed. This process may take 14-21 days to provide this information. According to Colorado State Statutes, there may be a fee associated with your request, which may be required in advance.