



Clinical Excellence. Compassionate Care.



## REQUEST FOR MEDICAL RECORDS & PERMISSION FOR RELEASE OF INFORMATION

**PLEASE SEND THIS REQUEST FORM TO PREVIOUS PHYSICIAN FOR MEDICAL RECORDS**

Records Requested from: Dr. \_\_\_\_\_

(Address) \_\_\_\_\_

\_\_\_\_\_  
Last name First name Middle name Maiden name

\_\_\_\_\_  
Street address City State ZIP

( ) \_\_\_\_\_

Telephone Last name under which records may be found (if different) Birthdate

Please send my records to (check one):

\_\_\_\_ 271 West County Line Road      \_\_\_\_ 300 Exempla Circle, Suite 370

Littleton, CO 80129-1901      Lafayette, CO 80026-3384

FAX: 303-794-2054      FAX: 303-449-1039

Please send the following items to the address checked above. Please provide a complete copy of all medical records, rather than a summary. Thank you for your time and promptness.

Records of care from \_\_\_\_\_ to \_\_\_\_\_ to include anything that could have a bearing on my fertility.

\_\_\_\_ Medical records/ operative reports      \_\_\_\_ Laboratory reports      \_\_\_\_ Hysterosalpingogram x-rays and reports  
\_\_\_\_ Biopsy slides      \_\_\_\_ Other (please specify) \_\_\_\_\_

I hereby grant permission for release of these records.

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Date)

APPOINTMENT DATE \_\_\_\_\_

*PLEASE RETURN A COPY OF THIS FORM WITH THE PATIENT'S RECORDS*