



**CONCEPTIONS**  
REPRODUCTIVE ASSOCIATES  
OF COLORADO

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**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)			Birth Date

Please send my records to (check one):

<input type="checkbox"/> <b>Send to Littleton Clinic</b> 271 W County Line Rd Littleton, CO 80129 Phone: 303-794-0045 <b>Fax: 303-794-2054</b>	<input type="checkbox"/> <b>Send to Lafayette Clinic</b> 300 Exempla Circle #370 Lafayette, CO 80026 Phone: 303-449-1084 <b>Fax: 303-449-1039</b>	<input type="checkbox"/> <b>Send to Denver Clinic</b> 4500 E. 9th Ave #630 Denver, CO 80220 Phone: 303-720-7887 <b>Fax: 720-763-9140</b>
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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**

CONCEPTIONS REPRODUCTIVE ASSOCIATES OF COLORADO

www.conceptionsrepro.com

271 West County Line Road  
Littleton, Colorado 80129  
**T: 303.794.0045 F: 303.794.2054**

4500 E. 9th Avenue, Suite 630  
Denver, Colorado 80220  
**T: 303.720.7887 F: 720.763.9140**

300 Exempla Circle, Suite 370  
Lafayette, Colorado 80026  
**T: 303.449.1084 F: 303.449.1039**