



Authorization for Release of Medical Records

Patient Information

	/	/	
Last	First	M.I.	Date of Birth

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Release To:	Foothills Urogynecology, P.C. Terry Dunn, M.D. Marsha Merry, WHNP-BC 850 East Harvard Avenue, Suite 285 Denver, Colorado 80210 P: 303.282.0006 F: 303.282.0066	Please Fax All Requested Information To: (303) 282-0066
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Release From:	
	Name/Title/Organization
	Address
	City, State & Zip
Phone:	Fax:

The information you may release subject to this signed release form is as follows:

<input type="checkbox"/> Complete Record	<input type="checkbox"/> Lab/Radiology Reports	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Operative Reports	<input type="checkbox"/> History and Physical	

X	Initial Here	HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infections, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records.
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SIGN HERE →	Signature of Patient, Legal Guardian or Authorized Representative	/ /	Date (mm/dd/yyyy)
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