3744 South Timberline Road, Suite 102
Fort Collins, CO 80525
(970)495-0506 Fax: (970)495-0485

AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____Phone#:_____

OBTAIN FROM: _____ (Releasing facility)
Phone #: _____Fax #: _____

RELEASE TO:_____ (Receiving facility)
Phone #: _____Fax #: _____

I hereby give the releasing facility permission to disclose my individually identifiable health information as listed below. I understand that once this information is disclosed, it may no longer be protected by Front Range Pain Medicine, LLC I understand that this authorization is voluntary, that further treatment can not be conditioned upon my signing this authorization, and that there may be a cost to copy the records.

Date of service range (month/year): From: _____To:_____

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY):

All Records____
Clinic/Progress Notes____ Other Information: _____

PURPOSE FOR THE DISCLOSURE: To obtain medical records for pain management treatment

AUTHORIZATION: I understand that I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand that this consent will expire 180 days from the date of my signature unless I provide notice in writing that it should be revoked. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy of facsimile of this form is to be considered as valid as the original.

PATIENT'S ACKNOWLEDGEMENT OF ACCESS TO MEDICAL RECORDS
I hereby acknowledge that I the patient/authorized representative have reviewed and/or received photocopies of the medical records from the Front Range Pain Medicine, LLC for the above named patient.

Signature _____**Date**_____

Signature of Patient Representative (required if the patient is a minor or an adult who is unable to sign this form)_____Date _____
Relationship to Patient_____