



AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT NAME: _____ DOB: ____/____/____

PATIENT ADDRESS: _____

HOME NUMBER: (____) _____ CELL NUMBER: (____) _____

***THERE MAY BE A FEE FOR RECORDS ***

RELEASE RECORDS TO:
 RELEASE RECORDS FROM:

RELEASE RECORDS TO:
 RELEASE RECORDS FROM:

Boulder Endocrinology, PLLC

892 West South Boulder Road

Louisville, CO 80027

PHONE: 303-586-5200

PHONE: _____

FAX: 303-586-5201

FAX: _____

I AUTHORIZE BOULDER ENDOCRINOLOGY OR THE FACILITY LISTED ABOVE TO RELEASE THE INFORMATION SPECIFIED BELOW:

INITIALS

_____ ALL MEDICAL RECORDS GENERATED BY THIS FACILITY

_____ LABS ONLY

_____ OTHER RECORDS: _____

WILL YOU BE LEAVING OUR PRACTICE? YES, NO, N/A

THIS AUTHORIZATION WILL EXPIRE AFTER 90 DAYS

PATIENT SIGNATURE OR LEGAL REPRESENTATIVE/ RELATIONSHIP

DATE