FREMONT COUNTY DEPARTMENT OF
PUBLIC HEALTH & ENVIRONMENT
201 N. 6th Street
Cañon City, CO 81212
P: 719-276-7450 F: 719-276-7451

Authorization for Release of Medical Records

Patients Name: ____ **Sex: M / F**

DOB: ____________________ **Phone:** _______________________

Address: _____________________________________**City:**________________ **State:** ______ **Zip:** ________

If Minor: **Parent/Legal Guardian:** ____ **Phone:** ________________

RELEASE INFORMATION FROM:

Name: ____

Address: _______________________**City:**__________ **State:** _____ **Zip:** ________

Phone: _________________________ **Fax**: ____

State/Federal Laws require specific authorization to release the following types of information

Requested Information: ____

Method of delivery: ☐ Mail ☐ Fax ☐ Will pick up

RELEASE MEDICAL INFORMATION TO:

Name: ____

Address: _______________________**City:**__________ **State:** _____ **Zip:** ________

Phone: _________________________ **Fax**: ____

PATIENT/AUTHORIZED REPRESENTATIVE AUTHORIZATION

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

____ ______________________

Signature of Patient/Parent/Legal Guardian Date