Northeast Colorado Family Medicine Associates, P.C.

Curtis C. Clark, M.D./Charles A. Gerk, M.D./Stacey Rhodes, PA-C/Rachelle Maker FNP-C

Release of Medical Records

Name of Patient:_____

DOB: _____ Phone: _____

Address:_____

I authorize the release of my protected medical records as requested below:

☐ To ☐ From Northeast Colorado Family Medicine Associates, P.C.
1405 S. 8th Ave . Suite 103
Sterling, CO 80751
Phone: 970-522-3304 Fax: 970-522-4615

Attention: ☐ **Curtis C. Clark, M.D.** ☐ **Charles A Gerk, M.D.** ☐ **Stacey Rhodes, PA-C** ☐ **Rachelle Maker, FNP-C**

☐ To ☐ From _____

_____

_____

Phone: _____

Fax: _____

Are you transferring care? **Yes** **No**

Dates Requested: *Last 2 years only* unless otherwise specified below:

From (date) :_____ **To(date) :_____**

Information to be released: (Reports may include information on drug/alcohol/psychological/HIV or communicable disease treatment.)

Records requested:

__History & Physical __Consultations __EKG __Hospital Visit __Xrays

__Office Visits/Progress Notes __Psychological/Psychiatric History & Assessment

__**Complete Medical Record** __Other_____

Purpose for Release of Information:

__Personal Use __Legal Purposes __Insurance __Continuing Medical Care

__Social Security/Disability __Other_____

I understand that I may revoke this consent anytime except to the extent that action has already been made before receipt of revocation. This authorization expires automatically one hundred eighty (180) days from the date of signature or as otherwise specified**. <u>I understand that I may be charged for copies of my medical records.</u>** I understand that these records are protected under federal/state law and cannot be disclosed without my consent otherwise provided by law. Releasing office will not be responsible for dissemination or disclosure of your confidential medical information once we provide such information, at your request, to your health insurer, employer, attorney or other designee.

Date:_____ **Signature**: (patient/guardian) _____

*** If records are over 15 pages, please do not fax. Please mail to the address provided above. Thank you! - Medical Records**