Western Valley Family Practice

Redlands After Hours
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2237 Redlands Parkway Grand Junction, Colorado 81507
Main: 970-858-9894 or 970-243-1707 • Fax: 970-858-1331 • www.westernvalleyfp.com

FAXED OR EMAILED RECORDS RELEASES MUST BE ACCOMPANIED BY PARENT OR GUARDIAN PICTURE ID AND WITNESS FULL SIGNATURE, ADDRESS, AND PHONE NUMBER

Consent to Release Information Via: □ **Secure Fax** (to another Medical Provider only)

□ **Mail** □ **Pick Up Date**_____ (Allow 5 Working Days)

I authorize:
Name:
_____
Address:
_____
_____
Phone: Fax:
_____

To release to:
Name:
_____
Address:
_____
_____
Phone: Fax:
_____

This form authorizes the release of the requested information on the below named patient:
(One patient per form please)

Patient Name:
_____

Date of Birth:
_____

Information Requested:
□ Standard Records (last 3 yrs office visits, physicals, vaccines, labs, hospital notes)
□ Records for specialist referral
□ Limited Records (event, dates:_____)
□ Immunization Records

Reason(s):
□ Referral
□ Consult
□ Moving
□ Changing Doctors
□ Insurance
□ Other_____
_____
_____
_____
_____

First copies no charge; any extra copies will include a copying fee. Western Valley Family Practice does not release other providers notes.

I request and authorize the above named provider/s to release this information. I understand the records may include information regarding the following conditions: drug or alcohol abuse, psychological or psychiatric conditions, developmental disabilities, HIV, AIDS, sexually transmitted diseases, pregnancy, or other sensitive information. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment, my eligibility for benefits, etc. will not depend in any way on whether I sign this authorization or not. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. This authorization expires 120 days from the signed date below. A copy of this authorization will serve as a valid original.

_____ _____ _____
Print Name Relationship to Patient Signature

_____ _____ _____ _____
Phone Number Date Witness Signature Date

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Western Valley Family Practice._____ _____
Signature Date