FRONT RANGE
EYE PHYSICIANS

205 S. Main St., Suite D - Longmont, CO 80501
Phone: (303) 772-3611
Fax: (303) 772-3609

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

_____ _____
Patient Name Patient Date of Birth

_____ _____
Patient Phone Number Patient Email Address

OBTAIN RECORDS FROM:

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Phone: _____ Fax: _____

RELEASE RECORDS TO:

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Phone: _____ Fax: _____

We will request the most recent two (2) years of records unless otherwise specified:

_____

I hereby authorize Front Range Eye Physicians PC to obtain or release the specified information as stated on this form. I understand that the information in my health record may include information relating to sexually transmitted diseases, HIV/AIDS, mental health, and drug or alcohol abuse. I understand that records from other doctors' offices will not be included.
I hereby release Front Range Eye Physicians PC and its employees from any and all liability that may arise from the release of information as I have here directed. I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it. Unless revoked, this authorization will expire 1 year after date of signature.

Patient Signature: _____ Date Signed: _____

Parent/Guardian Signature_____ Date Signed: _____