**Release of Medical Records Form**

**MALE-1**

**To:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Doctor's Name Clinic Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

City State Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number Fax Number

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Your Doctor's Name

to release any individually identifiable health information related to me **FROM THE PREVIOUS TWO YEARS**, which is called protected health information (PHI) under a federal health privacy law, as described below (please check all that apply) to **Allura Skin, Laser, and Wellness Clinic**:

* PSA
* Testosterone, Estradiol
* CBC or HCT
* Thyroid Panel
* Lipid Panel
* Chemistry Panel
* Prostate ultrasound and/or biopsy results

**FAX TO:** **Allura Skin, Laser, and Wellness Clinic**

Dr. Rebecca de la Torre

2032 Lowe Street; Suite 103 4450 Johnstown; Suite 201

Fort Collins, CO 80525 Johnstown, CO 80534

**Fax: 970-669-5348** Phone: 970-223-0193

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

**Release of Medical Records Form**

**For Ongoing Medical Release of Lab, Sonographic, and Pathology**

**Reports and Results MALE-2**

**To:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name Clinic Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

City State Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number Fax Number

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Your Doctor's Name

This form serves to authorize my physician’s office to release any and all identifiable health information related to me 🡪 lab, sonographic, and pathology reports/results to **ALLURA SKIN, LASER, and WELLNESS CLINIC** ordered during \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 201\_\_\_ through \_\_\_\_\_\_\_\_\_\_ 201\_\_\_.

**Pertinent Reports:**

* Hormone Results: Testosterone, Estradiol
* PSA
* CBC or HCT
* Chemistry Panel
* Lipid Panel
* Thyroid Panel
* Prostate ultrasound and/or biopsy results

**FAX TO:** **Allura Skin, Laser, and Wellness Clinic**

Dr. Rebecca de la Torre

2032 Lowe Street; Suite 103 4450 Johnstown; Suite 201

Fort Collins, CO 80525 Johnstown, CO 80534

**Fax: 970-669-5348** Phone: 970-223-0193

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Print Name Date of Birth

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Patient Signature Date

**Release of Medical Records Form**

**For Ongoing Medical Release of Lab, Radiographic, Sonographic, and Pathology Reports and Results MALE-3**

**To:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital or Laboratory

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

City State Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number Fax Number

This form serves to authorize my hospital or laboratory to release any and all identifiable health information related to me 🡪 lab, radiographic, sonographic, and pathology reports/results to **ALLURA SKIN, LASER, and WELLNESS CLINIC** ordered during \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 201\_\_\_ through \_\_\_\_\_\_\_\_\_\_ 201\_\_\_.

**Pertinent Reports:**

* Hormone Results: Testosterone, Estradiol
* PSA
* CBC or HCT
* Chemistry Panel
* Lipid Panel
* Thyroid Panel
* Prostate ultrasound and/or biopsy results

**PLEASE FAX REPORTS TO:** **Allura Skin, Laser, and Wellness Clinic**

Dr. Rebecca de la Torre

2032 Lowe Street; Suite 103 4450 Johnstown; Suite 201

Fort Collins, CO 80525 Johnstown, CO 80534

**Fax: 970-669-5348** Phone: 970-223-0193

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Print Name Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date