1491 N. DENVER AVE, STE 101, LOVELAND, CO 80538
PHONE:(970) 663-2225, FAX:(970) 593-6748

CONSENT TO ACCESS/RELEASE MEDICAL RECORDS

PATIENT NAME_____ DATE OF BIRTH _____

INFORMATION REQUESTED_____

REASON THE INFORMATION IS NEEDED_____

IF MEDICAL RECORDS NEED TO BE SENT EITHER TO OR FROM THIS FACILITY, PLEASE COMPLETE THIS BOX BELOW:

- ❑ I REQUEST THAT SCOTT FAMILY HEALTH SENDS MY MEDICAL RECORDS TO THE FOLLOWING LOCATION:
- ❑ I REQUEST THE FACILITY LISTED BELOW SEND MY MEDICAL RECORDS TO SCOTT FAMILY HEALTH:

NAME:_____

ADDRESS:_____

PHONE NUMBER:_____FAX NUMBER:_____

A COPY OF THIS RELEASE MAY BE USED IN PLACE OF THE ORIGINAL. THIS CONSENT HAS BEEN MADE VOLUNTARILY AND IS VALID FOR 180 DAYS. I UNDERSTAND I MAY REVOKE THIS CONSENT AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN TO COMPLY WITH IT. I UNDERSTAND THAT THIS AUTHORIZATION WILL NOT APPLY TO ADMISSIONS OR CARE PROVIDER AFTER THE DATE OF MY SIGNATURE. I HAVE READ THE ABOVE AND ACKNOWLEDGE THAT I UNDERSTAND THE TERMS AND CONDITIONS OF THIS CONSENT. I RELEASE THE ABOVE FACILITY FROM ANY LIABILITY IN COMPLYING WITH THIS CONSENT.

_____

PATIENT OR DESIGNATED REPRESENTATIVE SIGNATURE DATE

_____

RELATIONSHIP TO PATIENT IF SIGNED BY DESIGNATED REPRESENTATIVE

OFFICE USE ONLY: DATE COPIED _____# OF PAGES_____
CLERK_____

SCOTT FAMILY HEALTH IS MADE UP OF DR. TRENTON SCOTT, DR. GINA SCOTT, DR. SCOTT HESSLER, DR. STACIE HOWELL