BOULDER PLASTIC SURGERY Prof., L.L.C.
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www.boulderplasticsurgery.com

Patient Name: ______________________________

Date of Birth: _____/_____/_____

SSN: _____/_____/_____

AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

OBTAIN FROM: (Releasing facility)	RELEASE TO: (Receiving entity)
Name	Name
Address	Address
City Zip	City Zip
(_____)	(_____)
Phone Fax	Phone Fax

I hereby give the releasing facility permission to disclose my individually identifiable health information listed below. I understand that this authorization is voluntary, that further treatment can now be conditioned upon my signing this authorization.

Date of service range (month/year): From:______________________ To:______________________

___ Emergency Room Report
___ Discharge Summary
___Operative Report
___ Historical and Physical
___ Clinic/Progress Notes
___ Radiology Reports
___ Laboratory Reports
___ Other test Results
____ Mammogram

Information is to be used for:

___ Continuity of Medical Care ___ Damage/Claim Information ___ Personal Use

___ Other______________________

Authorization: I understand that I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand that this consent will expire 180 days from the date of my signature unless I provide notice in writing that it should be revoked. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy of facsimile of this form is to be considered as valid as the original.

Signature of Patient or Authorized Representative ______________________ Date of Signature ______________________

Printed Name ______________________ Relationship to Patient (if applicable) ______________________

PATIENT'S ACKNOWLEDEMENT OF ACCESS TO MEDICAL RECORDS
I hereby acknowledge that I the patient/authorized representative have inspected and or received photocopies of the medical records from Boulder Plastic Surgery for the above named patient.

Date ________ Signature ______________ Date ________ Witness Signature ______________