



**10455 Park Meadows Drive #102
Lone Tree CO 80124
303-708-0246 – Phone
303-708-0247 – Fax**

**please provide
Valid I.D.**

Authorization to release medical information

Please note that if this form is not completely filled out records will not be processed.

Patient: _____ **DOB:** _____

Address: _____ **Phone:** _____

City: _____ **State:** _____ **Zip:** _____

Please select the doctor that you normally see in our office:

_____ Dr. Randall Snook _____ Dr. Dennis Furr _____ Dr. Jennifer Hepp
_____ Jodie Gahn _____ Katie Young _____ Dr. Dina Elias

Information to be disclosed:

___ Entire Chart ___ Hospital Records ___ Immunization records
___ Consulted Second opinion ___ CT report ___ Lab reports
___ Date of last physical ___ Clinical Notes ___ Phone Consult

Please provide us with the information of the office you would like us to send records to.

Name of office/doctor Receiving records	
Address	
Phone#	
Fax #	

X _____

Signature of patient/Guardian

Relationship to patient if guardian

Date

***Per Colorado Fee Schedule 18-6 charges apply as follow: \$18.50 for the first 10 pages; \$.85 for pages 11-40; \$.57for pages 41+ \$14 for computer disc; \$.10 per electronic pages**