



STACY J. CHILDS, M.D., F.A.C.S.
JAMIE VANOVEREN, D.O.

Steamboat Springs Office: **REQUEST FOR RELEASE OF MEDICAL RECORDS**

Phone: (970) 871-9710

Fax: (970) 871-9709

Craig Office:

Phone: (970) 826-0301

Fax: (970) 826-0698

Patient's Name (Print): _____ Date of Birth: _____

Social Security #: _____

Release Records To: Self Other Physician/facility Other (please specify) _____

Name _____

Address _____

City _____ State _____ Zip _____

Phone (_____) _____ Fax (_____) _____

General Authorization: I authorize the above named health care provider to release the information specified below to the organization, agency or individual named on this request. I agree to pay the facility's reasonable charge for copying any documents, and I understand that the facility may require up to 30 days time to copy and release records.

Specific Authorization: I specifically authorize the release for information regarding the following condition(s)

** Initial boxes as appropriate**

- () Drug Abuse or Alcohol Abuse, if any
- () HIV Information
- () Psychological or Psychiatric Conditions
- () Diagnosis of Sexually Transmitted Diseases

Information Requested:

- () Copy of Complete Medical Records
- () Copy of Outpatient Records
- () Copy of Operative Reports
- () Copy of Labs and Xrays
- () Other, please specify:

Conditions(s) and dates of care covered:

- () All past Admissions or care by this office as of date of signature
- () Limited to the treatment date and for conditions described below

Purpose or need for Authorization:

- () Insurance or Payer Claim
- () Change of doctor
- () Other, please specify:

Expiration of Revocation of Authorization: I understand that I may revoke this authorization in writing at anytime, except to extent that action has already been taken to comply with it. I understand that this authorization will not apply to admission or care provided after the date of my signature. Even if I do not revoke this authorization, it will automatically expire:

- () 180 days from the date of my signature
- () On the following date: _____

Signature of patient or legal Guardian or Designated Representative

Date