Urology Clinic P.C.

Jaime L. VanOveren D.O.
Clay M. Pendleton M.D.

Steamboat Office
501 Anglers Drive Suite 202
Steamboat Springs, CO 80487
Phone 970-871-9710

Frisco Office
18 School Road Suite 125
Frisco, CO 80443
Phone 970-368-6247

Craig Office
114 East 8th Street
Craig, CO 81625
Phone 970-826-0301

Fax number all locations 970-871-9709

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

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

Social Security #: _____

Records Requested From:
Urology Clinic PC

_____
Name
501 Anglers Drive Suite 202
Address
Steamboat Springs CO 80487
City State Zip
(970) 871-9710 (970) 871-9709
Phone Fax

Release Records To:

_____
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 STDs

Information Requested:

( ) Copy of History & Physical
( ) Discharge Summary
( ) Operative Reports
( ) Copy of Outpatient Reports
( ) Copy of Complete Medical Records
( ) Other, please specify:

Condition(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 admissions or care provided after the date of my signature. Even if I do not revoke this authorization in writing, this authorization 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