AUTHORIZATION to RELEASE MEDICAL RECORDS/INFORMATION

Patient's name:_____

Street:_____City:_____State:_____Zip Code:_____

DOB_____

Person to receive records (name and address):

Alan P. Aboaf, MD, FACP
Arthur A. Burroughs, MD
Juliana Sheehan, PA-C
Emily Delzer, PA-C
Danielle Collins, PA-C

Aurora Internal Medicine Clinic, P.C.
13111 E. Briarwood Ave. Suite 250
Centennial, Colorado 80112
Phone: 303-805-1800
Fax:303-805-9323

I authorize any previous or current health care providers or facilities to release the information specified below to the organization, agency, or individual named on this request. I specifically authorize the release of information regarding the following condition(s):

Release these records:
Initials

1. Only records generated by this facility (not including records received from other sources)_____
2. Only some portion of records maintained at facility (specify below)_____
3. All medical records at this facility_____

Expiration or revocation of authorization-I understand that I may revoke this authorization at any time.

Use of copies-A copy of this authorization may be utilized with the same effectiveness as an original.

Patient name (print):

Person authorized to sign for patient:

_____ _____

SIGNATURE

Patient's signature:

_____ Date:_____