***Blue Skies Center for Women***
*140 Parkside Drive*
*Colorado Springs, CO 80910*
*719-471-3471; FAX: 719-471-0744*

Andrew Fowler, MD  Stephanie Fowler, MD
Deborah Chan, MD  Carol Hurst, CNM
Terri Hamm-Johnson, RNC CNP
Debra Baker, RxN CNP  Judy Oldendorf, RNC CNP

## AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

PHYSICIAN OR FACILITY TO PROVIDE RECORDS: ***Blue Skies Center for Women***
140 Parkside Drive
Colorado Springs, CO 80910

PATIENT'S NAME: _____

SOCIAL SECURITY #: _____-_____-_____ DOB: _____/_____/_____

PERSON OR PROVIDER TO **RECEIVE** RECORDS: (NAME & ADDRESS)_____

_____

***ARE YOU TRANSFERRING YOUR CARE TO ANOTHER PROVIDER? YES NO***
***IF YES, PLEASE EXPLAIN***_____

_____

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**I AUTHORIZE THE HEALTH CARE PROVIDER TO RELEASE THE INFORMATION SPECIFIED BELOW TO THE ORGANIZATION, AGENCY, OR INDIVIDUAL NAMES ON THIS REQUEST. I SPECIFICALLY AUTHORIZE THE RELEASE OF INFORMATION REGARDING THE FOLLOWING CONDITION(S):**

INITIALS:

_____ DRUG ABUSE, IF ANY
_____ PSYCHOLOGICAL OR PSYCHIATRIC CONDITIONS, IF ANY

INITIALS:

_____ SUBSTANCE ABUSE, IF ANY
_____ AIDS/HIV IF ANY

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**RELEASE RECORDS LISTED BELOW:** *CHOOSE ONE (1) OPTION ONLY*

| | INITIALS | | INITIALS |
|---|---|---|---|
| **ALL MEDICAL RECORDS AT THIS FACILITY** | _____ | **ONLY RECORDS GENERATED BY THIS FACILITY** | _____ |

**ONLY SPECIFIED RECORDS**
(SPECIFY)_____ INITIAL _____

**EXPIRATION OF 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

**AUTHORIZED PERSONS:** PERSON AUTHORIZED TO SIGN FOR PATIENT MUST HAVE MEDICAL DURABLE POWER OF ATTORNEY ATTACHED

_____
PATIENT NAME

_____ _____
PATIENT OR DESIGNATED PERSON SIGNATURE  RELATIONSHIP TO PATIENT

_____
DATE