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

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

AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

PHYSICIAN OR FACILITY TO PROVIDE RECORDS: _____

_____

_____

PATIENT'S NAME: _____

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

PERSON OR PROVIDER TO RECEIVE RECORDS: ***Blue Skies Center for Women***
140 Parkside Drive
Colorado Springs, CO 80910

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

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