Children's Eye Care
OF NORTHERN COLORADO

at UC Health Harmony Campus
2121 E. Harmony Rd., Suite 350A
Fort Collins, CO 80528
Phone # (970) 214-8175
Fax # (970) 788-7376

MEDICAL RECORDS RELEASE FORM

Patient Name (First / Middle Initial / Last):

_____

Patient Date of Birth (MM/DD/YY): _____

PLEASE SEND RECORDS TO ☐ **or** **PLEASE GET RECORDS FROM** ☐

Name: _____

Phone Number: _____ **Fax Number:** _____

Address: _____

PLEASE SEND THE FOLLOWING RECORDS:

☐	All Health Records
☐	Prescriptions only
☐	Records related to the following treatment _____

PATIENT RIGHTS

The patient understands they or their parent or guardian does not have to sign this authorization to receive health care benefits (treatment, payment or enrollment).

The patient may revoke this authorization in writing. If they do, it will not affect any actions already taken by Children's Eye Care of Northern Colorado, P.C. based on this authorization. The patient may not be able to revoke this authorization if the purpose was to obtain health insurance.

Once the patient's health information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____

Patient or Legal Guardian Signature **Date (MM/DD/YYYY)**

_____ _____ _____

Printed Name **Relationship** **Time**