



CENTER POINTE FAMILY MEDICINE
Authorization to Release Medical Information

Patient Name (Please Print)

Date of Birth

I hereby authorize:	To release information to:	Patient Address:
Center Pointe Family Medicine		
	Phone:	
Fax:		Phone:

Information Requested:

☒ Complete Chart

If not requesting complete chart, please indicate the information you are requesting: Circle All Applicable

Doctor's Notes	Lab Reports	Mental Illness, Psychiatric Treatment
X-Ray Reports	Immunization Records	Drug or Alcohol Abuse
HIV	Other (Please Specify)	

If only certain items are requested, please specify the dates of care: _____

Reason for record transfer:

☐ Moving ☐ Change of Insurance ☐ Legal ☐ Consult ☐ Other

I request and authorize Center Pointe Family Medicine to release the specific information to the individual named on this request. I am aware that this information may also include my current or past residences. Any patient 18 years of age or older must sign for their own records. To ensure timely processing of medical records, please fill authorization out completely. **CPFM works with CIOX Health to process all Medical Records Requests. Individual patient requests will be charged in accordance with Section 164.524(c)(4) of HIPPA's Privacy Regulations. Other requesters may be charged in accordance with applicable state law or such other fees as may be negotiated from time to time with third party requesters.**

Signature of Patient: _____ **Date:** _____

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North
5410 Powers Center Pt., Suite 230
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719-282-6106 - Fax

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719-390-4335 - Office
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Center Pointe Family Medical Group
Castle Rock
1 Oakwood Park Plz., Suite 101
Castle Rock, CO 80104
720-667-1825 - Office
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