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	
	☐ North Fax: (719) 282 - 6106	
	☐ South Fax: (719) 390 - 4566	
Phone:	☐ Castle Rock Fax: (720) 667 - 1830	
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_____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.

Signature of Patient:_____Date:_____

This form is being provided as a courtesy to our patients. It is the sole responsibility of the patients to obtain their medical records from previous physician offices.

Center Pointe Family Medicine
North

5410 Powers Center Pt., Suite 230
Colorado Springs, CO 80920
719-282-6100 - Office
719-282-6106 - Fax

Center Pointe Family Medicine
South

37 Widefield Blvd
Colorado Springs, CO 80911
719-390-4335 – Office
719-390-4566 – Fax

Center Pointe Family Medical Group
Castle Rock

1 Oakwood Park Plz., Suite 101
Castle Rock, CO 80104
720-667-1825 – Office
720-667-1830 - Fax