# Dalton's Family Medicine Medical Record Request

Patient Name:_________________________________________Date of Birth:____________
Patient's Address:_____________________________________________________________

Requestor's Name/ Phone Number (if patient is not the requestor):
__________________________________________________________________________

Records from:_______________________________________________________________
Phone: (          ) ___________________________ Fax: (          )________________________
Address:___________________________________________________________________

**Please send records to Dalton's Family Medicine:**
**651 Topeka Way, Ste 600 Castle Rock, CO 80109**
**Ph: (303) 728-9661    Fax: (303) 728-9786**

Description :
- ☐ Entire Medical Record
- ☐ Medication Record
- ☐ Progress Notes
- ☐ Demographics & Insurance
- ☐ Labs
- ☐ Other__________________________
- ☐ Imaging/Radiology

This authorization will expire on the following (date or event):________________________

Purpose of Disclosure:________________________________________________________

I understand that I may revoke this authorization at any time in writing . I understand that if the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed. I understand that I may see and obtain a copy of this form if I ask for it. I have read the above and authorize the disclosure of protected health information as stated.

_____________________________________________________          ________________
Signature of Patient/ Guardian/Patient Representative          Date

_____________________________________________________          ____________________
Print name of Representative          Relationship to Patient