General Medical Records Release

Authorization For Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: ________________________
Address: _____________________________ City _______________ State ______ Zip _______
Phone: _________________
Date of Birth _____________________

I authorize the custodians of records at (Provider/Entity): ___________________________

Address: __________________________ City: _____________ State ______ Zip ______

Phone: ______________ Fax _________________

To disclose/release the following information:
___ all records ___ office notes (previous 2 years) ___ pharmacy/prescription records
___ lab/pathology records (3 years) ___ radiology records (3 years)
___ other (describe): ____

Please send the records listed to:

Brighter Future Vision Clinic
Dr. Robb Johnson, O.D., FCOVD
325 East Horsetooth Road, Building 5 Suite 201
Fort Collins, CO 80525
Phone: 970-377-3111 Fax 970-282-0111

I understand that after the above stated custodian releases the information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. This consent may be revoked at any time by written notice to Brighter Future Vision Clinic. If the patient is under 18, this authorization must be signed by a legal adult or guardian.

Signature of Patient (or representative) ________________________ Date _____________

Relationship _______________________