



10455 Park Meadows Drive #102
Lone Tree, CO. 80124
303-708-0246 – Phone
303-708-0247 – Fax

Please provide
Valid I.D.

Authorization to release medical information

Please note that if this form is not completely filled out records will not be processed

Patient: _____ DOB: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Please select the doctor that you normally see in our office:

___ Dr. Snook ___ Dr. Furr ___ Dr. Hepp ___ Gina Caprara NP
___ Katie Young PA ___ Dr. Milling ___ Dina Elias

Information to be disclosed:

___ Entire Chart (Last 5 years only) ___ Immunizations ___ Lab Results
___ Progress notes (last 2 years only) ___ Radiology/Imaging
___ Other ___ Last Physical

Please provide us with the information of the office you would like to send records **FROM:**

| | |
|---|--|
| Name of Office/Doctor Sending Records | |
| Address | |
| Phone # | |
| Fax # | |

X _____
Signature of Patient/Guardian Relationship to patient Date