ADVANCED INTEGRATIVE MEDICINE

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 _____Immunizations _____Lab Results

_____Progress notes _____Radiology/Imaging

_____Other _____ Last Physical

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

Name of Office/Doctor **Receiving** Records	
Address	
Phone #	
Fax #	

X _____ _____ _____

Signature of Patient/Guardian **Relationship to patient** **Date**