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## MEDICAL RECORDS RELEASE

I, \_\_\_\_\_, DOB: \_\_\_\_\_ hereby authorize Deborah Meyers, CNP, MS / Sage Health Care, LLC, 88 Magpie Trl , Durango, CO 81301 / FAX number 970-403-8815 to:

**RELEASE / RECEIVE** (circle) the medical information from medical records listed below **TO / FROM** (circle) :

Practice Name and Address (as needed): \_\_\_\_\_

Practice Phone \_\_\_\_\_ Practice Fax Number \_\_\_\_\_

**Medical Records to be released:** (check all that apply)

\_\_\_\_\_ All Records

\_\_\_\_\_ Last 2 years of annual exam report

\_\_\_\_\_ Progress / Office Notes

\_\_\_\_\_ Lab Reports

\_\_\_\_\_ Diagnostic Imaging Reports (please specify) \_\_\_\_\_

\_\_\_\_\_ Other (please specify) \_\_\_\_\_

I understand that my records are protected under the Federal and specific State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. My information disclosed per this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I may revoke this consent in writing at any time.

\_\_\_\_\_  
**Signature of Patient or Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Witness**

\_\_\_\_\_  
**Date**