FREMONT COUNTY DEPARTMENT OF PUBLIC HEALTH & ENVIRONMENT
201 N. 6th Street
Cañon City, CO 81212
P: 719-276-7450 F: 719-276-7451

Authorization for Release of Medical Records

Patients Name: ______________________________ **Sex:** **M / F**

DOB: ____________ **Phone:** ______________

Address: ______________________ **City:** __________ **State:** _____ **Zip:** ______

If Minor: **Parent/Legal Guardian:** ______________________ **Phone:** __________

RELEASE INFORMATION FROM:

Name: Fremont County Department of Public Health & Environment

State/Federal Laws require specific authorization to release any medical information.

Requested Information: ______________________________

Method of delivery: ☐ Mail ☐ Fax ☐ Will pick up

RELEASE MEDICAL INFORMATION TO:

Name: ______________________________

Address: ______________ **City:** ________ **State:** _____ **Zip:** ______

Phone: ______________ **Fax:** ______________________

PATIENT/AUTHORIZED REPRESENTATIVE AUTHORIZATION

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

______________________________ ______________

Signature of Patient/Parent/Legal Guardian Date