



The  
Thayer Group  
for  
Women's Care, PC

phone 303-443-2010 • fax 303-443-7882  
1155 Alpine Avenue • Suite 230 • Boulder, CO 80504

## Medical Records Release Form

Patient's Name (Print) \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Signature: \_\_\_\_\_ Witness: \_\_\_\_\_

Representative's Name (Print): \_\_\_\_\_ Relationship \_\_\_\_\_

(Please attach legal documentation of authority if signer is not the patient)

### I authorize information to be disclosed to the following individual or organization:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I authorize the release of my medical records for the purpose of: \_\_\_\_\_

I do hereby authorize the release of my medical records with my signature as follows:

I authorize release of medical records and tests provided through your office I understand that the medical information released by this authorization - includes information concerning physical treatments and diagnosis - and past medical history.

I understand this authorization will expire, without express revocation, one year from the date of signing, or if a minor, on the date I become an adult.

I understand that I may revoke this authorization in writing at any time. Revocation will not apply to information that has already been released - or to my insurance carrier when the law provides them with the right to contest.

I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization.

The Thayer Group for Women's Care, PC (David O. Thayer, MD) cannot condition treatment or payment on the signing of an authorization, except as otherwise permitted by law.

Return my records to the active file       Switch my records to the inactive file

I acknowledge and accept responsibility for full payment of any outstanding balance on my bill.

I also agree to pay the charges (below) for copies made of my records.

\$14.00 for 10 or fewer pages    \$0.50 per page for pages 11-40    \$0.33 per page after 40 pages

It takes up to 5 business days for records to be released.

Please send my records via     Mail     Fax

### INFORMATION REQUESTED:

Copy of medical records from the Thayer Group for Women's Care, PC

Copy of complete medical records

Copy of OB records

Other \_\_\_\_\_

**OFFICE USE ONLY:**

Request and record reviewed by _____	Date _____
Copied by _____	Date _____
Sent by _____	Date _____