



*The
Thayer Group*
for
Women's Care, PC

phone 303-443-2010 • fax 303-443-7882
1155 Alpine Avenue • Suite 230 • Boulder, CO 80304

Medical Records Request 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 Thayer Group for Women's Care, PC
1155 Alpine Avenue Suite 230
Boulder, CO 80304**

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.

INFORMATION REQUESTED:

- Copy of medical records from Dr. _____ office only
- 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 _____