

**Eye Center of Northern Colorado
Request for Medical Attention**

Patient Name: _____
(Print) Last First Middle

Soc. Sec. # _____ Telephone # _____ Date of Birth: _____

I hereby authorize: _____

to release the specified information as stated in this authorization to:

Eye Center of Northern Colorado, P.C.
1725 E. Prospect Road
Fort Collins, CO 80525
(970) 221-2222
Fax (970) 221-4286

This authorization is for release of medical records and information including diagnosis, treatment, and/or examination related to mental health, drug and/or alcohol abuse. HIV testing/AIDS and sexually transmissible diseases.

I understand that this authorization will remain in effect for 30 days from the date of signature or until I revoke it if sooner.

Describe the information desired to be released

Patient Signature: _____ Date: _____

Signature of Parent or Guardian _____ Date: _____

Relationship to Patient: _____

Witness: _____ Date: _____