EYE CENTER
OF NORTHERN COLORADO, P.C.
1725 E. Prospect Road
Fort Collins, Co. 80525-1307
Phone: (970) 221-2222 Fax: (970) 221-4286

AUTHORIZATION TO OBTAIN HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Telephone: _____

OBTAIN RECORDS FROM (required):	RELEASE RECORDS TO: (required):
Name: _____	Name:_____
Address: _____	Address:_____
City: _____	City: _____
State: _____ Zip Code: _____	State: _____ Zip Code: _____
Phone: _____ Fax:_____	Phone: _____ Fax: _____

We are requesting the most recent two years of records unless otherwise specified.

_____

_____

I hereby authorize the Eye Center of Northern Colorado, P.C. to obtain the specified information as stated in this authorization. I understand that the information in my health record may include information relating to sexually transmitted diseases, HIV/AIDS, mental health and drug or alcohol abuse. We will not include records from other doctors' offices. I hereby release the Eye Center of Northern Colorado, P.C. and its employees from any and all liability that may arise from the release of information as I have directed. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Without my express revocation, the authorization will automatically expire one year from the date of signature.

Patient Signature: _____ Date Signed:_____

Parent/Guardian Signature: _____ Date Signed: _____