Medical Record Number:___________________

For Office Use Only

(Date & Initial lines when complete)

New Request Sent to Health Info ___________

Received by Clinic Representative __________

Form Completed & Sent to Health Info_________

Health Info sent to appropriate parties _________

1725 E. Prospect Road Fort Collins, Co. 80525-1307

Phone: (970) 221-2222 Fax: (970) 221-4286

PATIENT PAPERWORK COMPLETION/ LETTER REQUEST

Patient's Name: ____ **Today's Date:** ________________________

Date of Birth: ___________________ **Contact Number(s):** ____

Did or will you miss work/school/trip? Yes___________ No ___________ Not Applicable___________

If so, what dates? ____

Reason work/school/trip was/will be missed: ____

Type of Form: (i.e., FMLA, insurance, disability, letter etc.) ____

How would you like to receive your form? (Select all that apply) __ Call me when ready to pick up at this number: ____________

__ Mail to this address: _______________________________ __ Email to this email address: ________________________

__ Fax to this number: ________________________________ __ Other: ____

If picking up which location, would you like to pick up from:

Prospect	Precision	Skyline
Centerra	Fox Run	Harmony

When do you need your form/letter? ________________ **Please note paperwork can take up to 2 weeks to complete.**

Any additional information that we need to know? ____

Authorization for the Disclosure of Health Information

Information released from:

Eye Center of Northern Colorado
1725 E Prospect Rd
Fort Collins, CO 80525

Information to be released to:

Name of receiver: ______________________________

Address:______________________________________

____

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. 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: _______________