

STEAMBOAT SPRINGS WOMEN'S CLINIC

940 Central Park Drive, Suite # 209
Steamboat Springs, CO 80487
Phone: 970-879-3738 Fax: 970-870-6441

"Caring for Women in all Phases of Life"

PATIENT NAME: _____ DOB: _____

SS# _____

REQUEST RECORDS FROM:

DR. NAME: DR. DAVID SCHALLER _____

CLINIC NAME: STEAMBOAT SPRINGS WOMEN'S CLINIC _____

PHONE NUMBER 970-879-3738 FAX: 970-870-6441 _____

ADDRESS: 940 CENTRAL PARK DR. # 209 CITY: STEAMBOAT SPRINGS STATE: CO 80487 _____

SEND RECORDS TO:

DR. NAME: _____

CLINIC NAME: _____

PHONE NUMBER _____ FAX: _____

ADDRESS: _____ CITY: _____ STATE: _____

I authorize the above health care provider to release the information specified below to the organization, agency, or individual named on this request. I understand that the facility may require up to 30 days time to copy and release my records.

INFORMATION REQUESTED

_____ COMPLETE MEDICAL RECORDS
_____ SURGICAL RECORDS W/ PATHOLOGY
_____ OTHER _____

_____ STD/HIV
_____ PSYCHIATRIC RECORDS
_____ DRUG/ SUBSTANCE/ ALCOHOL ABUSE

I understand that I may revoke this authorization in writing at anytime, except to extent that action has already been taken to comply with the records request. I understand that this authorization will not apply to admissions or care provided after the date of my signature or records that were not produced by this facility or provider.

Authorization will expire:

_____ 180 days from the date of my signature
_____ on the following date _____

Patient Name (print)

Person Authorized to Sign for Patient

Patient Signature

Relationship

Date