

**DTC Family Health**  
8301 E Prentice Ave Suite 125  
Greenwood Village, CO 80111  
(303) 771-3939 Fax (303) 771-4949

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone #: \_\_\_\_\_

**AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION**

I authorize the following facility: (Releasing facility)

To release information to: (Receiving facility)

DTC Family Health  
8301 E Prentice Ave Suite 125  
Greenwood Village CO 80111  
(303) 771-3939 Fax (303) 771-4949

\_\_\_\_\_  
(Facility/Provider Name)

\_\_\_\_\_  
(Complete Address, City, State, Zip)

\_\_\_\_\_  
(Phone #)

\_\_\_\_\_  
(Fax #)

**Information requested (check all that apply):**

Date of service range (month/year): From: \_\_\_\_\_ To: \_\_\_\_\_

- Complete Chart       History and Physical       Diagnostic Studies       Laboratory Reports  
 Radiology Reports       Pathology Reports       Progress Notes       Operative Reports  
 Mental Health Treatment \_\_\_\_\_ (Initial)       Drug/Alcohol Treatment \_\_\_\_\_ (Initial)       HIV/AIDS Info \_\_\_\_\_ (Initial)  
 Other (must specify): \_\_\_\_\_

Purpose of Release:  Treatment/Diagnosis     Insurance     Legal     Other: \_\_\_\_\_

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**Authorization:** I hereby give the releasing facility permission to disclose my protected health information as listed above. I understand that once this information is disclosed, it may no longer be protected. I understand that this authorization is voluntary. I understand that this authorization expires 90 days from the date of my signature. I understand that I can revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it. I release the above named, from liability and claims, of any nature, pertaining to the disclosure of the requested information contained in my medical records. A copy, fax or scan of this form is to be considered as valid as the original. I acknowledge that incomplete forms can not be processed and there may be a cost to copy the records.

\_\_\_\_\_  
Signature of Patient/Guardian/Personal Representative

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

*(If patient is unable to sign document for any reason)*

\_\_\_\_\_  
Date

**Note:** The process may take up to 30 days to provide this information. According to Colorado State Statutes, there may be a fee associated with your request, which may be required in advance. The charge is \$16.50 for the first ten or fewer pages, \$0.75 per page for pages 11-40, and \$0.50 per page for every additional page. Actual postage or shipping costs and applicable sales tax, if any, may also be charged.