# Authorization for Release of Medical Records

**PATIENT INFORMATION (PLEASE PRINT):**

Name:________________________________________Date of Birth:__________________

Address:____________________________________________________________

City: ____________________________State:___________________Zip:______________________________

Phone: (home)______________________(mobile)____________________(work)____________________

**RELEASE MY MEDICAL RECORDS**
**FROM:** Name:________________________________________________________

Address:________________________________________________________

Fax:____________________________________Phone:_____________________________________

**TO:** Nurture PLLC / Alison J Hoffmaster PA-C IFMCP
2299 Pearl Street, Suite 107 Boulder CO 80302
phone: (303)663-6480 fax: (303)595-5265

Please send my medical records no later than:_____________________________________________

Please send a copy of my medical records including:

____________History and Physical

____________Progress Notes

____________Lab Tests

____________Other Records:

___________Diagnostic Studies

___________Pap Smear (most recent)

___________Mammogram (most recent)

**BY MY SIGNATURE, I AUTHORIZE RELEASE OF MEDICAL RECORDS.**

________________________________________________________________**Date:**___________________
**Patient (or legal guardian) Signature**