Lorraine Caron, N.D.

1918 S. Lemay Ave., Ste. A ● Fort Collins, CO 80525 ● (970) 232-8447

Authorization to Disclose Medical Records

By law, this Authorization must be written, dated, and signed by the patient in order to release records.

_____ _____

Name of Patient Social Security Number

_____ _____

Home Phone Number Work Phone Number

I Hereby authorize:	**To send my medical records to:**
Name of person to authorize release of information:	**Name of person to receive information:** **Lorraine Caron, N.D.**
Name of clinic/hospital/agency:	**Name of clinic/hospital/agency:**
Street address:	**Street address:** **1918 S. Lemay Ave., Ste. A**
City, State, Zip code:	**City, State, Zip code:** **Fort Collins, CO 80525**
Phone and Fax numbers:	**Phone** **(970) 232-8447** **Fax** **(970) 692-2209**

This information will be used on my behalf for the following purpose and limited to (Date and Type of Treatment):

_____

_____

By **initialing** the spaces below, I authorize the release of the following medical records, if such records exist:

___ Entire medical record ___ Progress notes ___Laboratory reports

___ Pathology reports ___EKG ___ X-Ray

___Operative reports ___ Other (please specify_____

The following items must be initialed to be included in other documents:

___ HIV/AIDS related records ___ Mental Health records

___ Drug/ Alcohol diagnosis, treatment or referral information ___ Genetic testing information

(Federal regulations require a description of how much information and what kind of information is to be disclosed.)

Describe: _____

I understand that such information can not be released without my specific consent, except in a medical emergency. I further understand that this authorization is valid for 6 months from the date of signing unless revoked earlier in writing by the patient. The only exception is when the action has already occurred as instructed in the consent.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Legal Guardian if patient is a minor **Relationship** **Date**