# Mindy Miller MD

401 South Park, Montrose, CO 81401   970-240-8199

## Authorization for Release of Medical Information

I hereby authorize the release of information from the medical record of:

Patient Name: ________________________________ Date of Birth: ________________________

| Persons/ Organization **providing** the information: | Name/Fax number of Person/ Organization **receiving** information. |
| --- | --- |
| Mindy Miller, MD<br>**FAX # (970) 765 0330** | ________________________________________<br>________________________________________<br>________________________________________ |

**Please Release the Following:**

______ All Records ______ Radiology Reports ______ Consult Notes

______ EKG Reports ______Lab Reports ______ Immunizations

______Procedure Reports ______Progress Notes ______History/ Physical Exam

______ Other
______________________________________________________________________

**Purpose of Need for Disclosure:**

______ Continuity of Care ______ Personal Use ______Disability Determination

______ Other
______________________________________________________________________

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire on: (___/___/_____).

________________________________ ____________________
Signature of Patient or Legal Representative Date

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Relationship to Patient
Re