Linda Peterson MD
1404 Hawk Parkway, Suite 314, Montrose, CO 81401   970-615-8100

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.
Linda Peterson MD	____________________________________ ____________________________________ ____________________________________

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

____
Relationship to Patient
Re