CONCEPTIONS REPRODUCTIVE ASSOCIATES OF COLORADO

www.conceptionsrepro.com

271 West County Line Road 4500 E. 9th Avenue, Suite 630 300 Exempla Circle, Suite 370

Littleton, Colorado 80129 Denver, Colorado 80220 Lafayette, Colorado 80026

T: 303.794.0045 F: 303.794.2054 T: 303.720.7887 F: 720.763.9140 T: 303.449.1084 F: 303.449.1039

Mark R. Bush, M.D., FACOG, FACS

Michael S. Swanson, M.D., FACOG

Dana Ambler, DO, FACOOG

**REQUEST FOR MEDICAL RECORDS &**

**PERMISSION FOR RELEASE OF INFORMATION**

PLEASE SEND THIS REQUEST FORM TO PREVIOUS PHYSICIAN FOR MEDICAL RECORDS

Records Requested from: Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last name First name Middle name Maiden name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street address City State ZIP

(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Under which records may be found (if different)

Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please send my records to (check one):

**[ ] Send to Littleton Clinic**

271 W County Line Rd

Littleton, CO 80129

Phone: 303-794-0045

**Fax: 303-794-2054**

**[ ] Send to Lafayette Clinic**

300 Exempla Circle #370

Lafayette, CO 80026

Phone: 303-449-1084

**Fax: 303-449-1039**

**[ ] Send to Denver Clinic**

4500 E. 9th Ave #630

Denver, CO 80220

Phone: 303-720-7887

**Fax: 720-763-9140**

Please send the following items to the address checked above. Please provide a complete copy of all

Medical records, rather than a summary. Thank you for your time and promptness.

Records of care from \_\_\_\_\_\_\_\_to \_\_\_\_\_\_\_\_\_ to include anything that could have a bearing on my fertility.

\_\_\_\_ Medical records/operative reports \_\_\_\_ Laboratory reports \_\_\_\_ Hysterosalpingogram x-rays and reports

\_\_\_\_ Biopsy slides \_\_\_\_ other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby grant permission for release of these records.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name) (Date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Witness) (Date)

APPOINTMENT DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE RETURN A COPY OF THIS FORM WITH THE PATIENT’S RECORDS