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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