Presken Family Care

13111 East Briarwood Ave; Suite 360
Centennial, Colorado 80112
Telephone No.: 720.556.2001
Facsimile No.: 720.489.3731

Medical Records Release

Name: _____ Date of Birth: _____

Address: _____ City _____ State_____ Zip Code _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

All medical records are to be released, which includes all examination notes (annual examinations, obstetric/gynecological reports, abortion care, prostate, laboratory reports, imaging/diagnostic reports—x-ray, CT, MRI, etc.), and any other pertinent records.

Please transfer my medical records:

From: _____

Address: _____

Fax No.: _____

To: Presken Family Care, P.C.
13111 East Briarwood Ave; Suite 360
Centennial, CO 80112
Phone: 720.556.2001
Fax: 720.489.3731

I understand that my medical records are protected under state and federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections (including testing or treatment for HIV/AIDS), and diagnosis of mental illness or psychiatric care cannot be released without my written consent. Please initial below if you **DO NOT** want any of the following records released. ***Note: All applicable records will be released if nothing is marked.***

_____ Drug and/or alcohol abuse diagnosis or treatment

_____ HIV/AIDS testing and/or treatment

_____ Psychiatric care and/or mental illness

_____ Confirmed STI results and/or treatment

This consent can be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate one (1) year from the date signed.

Signature: _____ Date: _____

Witnessed by (*): _____ Relationship: _____

(*) To be signed by the witness if the patient is unable to do so.