Dr. Karen Kaufman, MD
www.kaufmanhealthandhormonecenter.com
phone: 720-639-2736

MEDICAL RECORDS REQUEST FORM

Patient Name: ____ DOB: _______________________

I authorize my medical information to be disclosed to the following individual or organization:

☐**Release FROM** ☐**Release TO**	☐**Release FROM** ☐**Release TO**
Kaufman Health & Hormone Center	Organization: ________________________________
Dr. Karen Kaufman, MD	Provider: ___________________________________
315 W. South Boulder Road #208	Phone: _____________________________________
Louisville, CO 80027	Fax: _______________________________________
Phone: 720-639-2736 Fax: 720-515-9520	

Purpose(s) for Information Use:

☐Further Eval/Treatment ☐Referral ☐Insurance/reimbursement
☐Other ____

Information requested:

☐Most Recent 2 Encounter Notes ☐Lab Results ☐Imaging Results
☐Other ____

☐Regarding these treatments/diagnosis ____
☐For the specific encounter date(s) ____
☐Please send information for the past 2 years from today's date.

Mark my patient file: ☐Active ☐Inactive

I understand that the medical information released may include information concerning treatments of physical and mental illness (excludes psychotherapy notes), alcohol/drug abuse and past medical history. I understand fees may be associated with the release of this information. If records are going directly to the patient, law firm or life insurance company the cost is $16.50 for the first 10 pages or less, $.75 for pages 11-40, and $.50 for page 41+ thereafter.

Expiration or Revocation of Authorization:

I understand this authorization will expire, without express revocation, 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization, or to my insurance when the law provides my insurer with the right to contest a claim under my policy itself.

I understand that any disclosure of information carries with it the potential for unauthorized disclosure and information may not be protected by federal confidentiality rules.

Patient Signature: ____ Date: _______________________

If needed:
Authorized Representative (print): ____
Relationship to Patient: ____
Authorized Representative Signature: ______________________________ Date: _______________________