Sarvjit S. Gill, MD, FACS
Sanjay Gupta, MD, FACS
Matthew L. Robertson, MD, FACS
Stephen M. Wold, MD, FACS
Blake J. Hyde, MD, FACS
Nicholas A. Quinn, MD
Thomas A. McKnight, MD
Kristen Fahrner, MD, FAAOA
Board Certified Otolaryngologists

Meg Ricci, PA-C
Andrea Bieganski, PA-C
Jeffrey Bundy, PA-C
Physician Assistants

Records Release Form

Date__________________

Name ____

Address ____

____

Date of Birth ____

Phone Number_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

I________________________________ **do hereby authorize**____
Medical Facility Name

To Release	**My medical Records From:**	**My Medical Records Sent To:**
Physician's Name	______________________	______________________
Address	______________________	______________________
City, State, Zip	______________________	______________________
Phone Number	______________________	______________________
Fax Number	______________________	______________________

1. All Health information (Circle one) YES NO
2. Specific information relating to:____

Name of Patient (print) ____

Signature of Patient or Patient Legal Representative____

Expiration date of authorization: This is effective for one year from the above date unless revoked or terminated by the patient or the patient's legal representative.

Are you transferring due to insurance or relocation ___ Yes ___ No
Are you transferring records due to leaving the practice? ___ Yes ___ No

If you are choosing to leave our practice; Please tell us why so we may try to prevent this from happening in the future.

____

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FORT COLLINS
1120 East Elizabeth Street #F-101
Fort Collins, CO 80524
(970) 221-1177
(970)484-5990 FAX

LOVELAND
3820 North Grant Avenue
Loveland, CO 80538
(970) 593-1177
(970) 593-0670 FAX

GREELEY
6500 W 29th St. #106
Greeley, CO 80634
(970) 330-5555
(970) 584-1055 FAX