ELEVATE
WOUND CARE | DENVER

Elevate Wound Care Records Requests
14789 W 87th Parkway
Arvada, CO 80005

Medical Records Release

PATIENT INFORMATION		
LAST NAME	FIRST NAME	
EMAIL	PHONE	DATE OF BIRTH
ADDRESS		

Information to be Released:

- ☐ All Records
- ☐ History & Physical (Most Recent)
- ☐ Lab Reports
- ☐ Other: _____
- ☐ Records from Date Range: _____
- ☐ Recent EKG
- ☐ Chart Notes

Reason for Request:

- ☐ Ongoing/Continuation of Care
- ☐ Other: _____

The above information may be released **to**:

_____
Name of Person or Entity to Release Information

_____
Street Address

City, State & Zip Code

_____ _____
Phone # Fax #

Requesting medical records **from:**

Elevate Wound Care Records Requests
14789 W 87th Parkway
Arvada, CO 80005

I understand that my medical records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that I do not have to sign this authorization in order to receive treatment from Elevate Wound Care. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to Elevate Wound Care. By signing, I authorize the release of information specified above.

_____ _____

Patient / Agent / Guardian Signature **Date** Relationship of Signer (If Other than Patient)