

Jeffrey V. Fowler, DO; FACOOG



**Obstetrics and Gynecology**

Eagleridge Women's Healthcare  
4728 Eagleridge Circle, Suite #110  
Pueblo, Colorado 81008

Tel: 719-583-2300  
Fax: 719-583-2301

**Record Release Form (F-2)**

Physician To Provide Records: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Send Requested Records To:**

Dr. Jeffrey V. Fowler, D.O., Prof. LLC 4728 Eagleridge Circle, STE. 110 Pueblo, Colorado 81008

Telephone: (719) 583-2300 Fax: (719) 583-2301

I authorize the healthcare provider to release the information specified below to the organization, agency or individual named on this request. I specifically authorize the release of information regarding the following:

**Release The Following Records:**

\_\_\_\_\_ All medical records including drug abuse, psychological or psychiatric conditions, substance Abuse, AIDS/HIV, sexually transmitted diseases, and all other sensitive information.

\_\_\_\_\_ Labs \_\_\_\_\_ Pathology \_\_\_\_\_ X-Ray/Ultrasounds \_\_\_\_\_ Visit Notes

\_\_\_\_\_ Pap Smear \_\_\_\_\_ Gonorrhea \_\_\_\_\_ Chlamydia \_\_\_\_\_ HPV

Other: \_\_\_\_\_

**Please State Reason For Records Transfer:**

\_\_\_\_\_ Obstetrical & Gynecological Care \_\_\_\_\_

I understand that I may revoke this authorization at any time. A copy of this authorization may be utilized with the same effectiveness as an original.

The purpose listed above is provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on \_\_\_\_/\_\_\_\_/\_\_\_\_. I do not have to sign this authorization in order to receive treatment. I also have the right to inspect or copy the information to be used or disclosed. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA 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 the Privacy Officer at the practice address.

Signed By: \_\_\_\_\_

Signature of Patient or Legal Guardian

\_\_\_\_\_

Relationship to Patient

\_\_\_\_\_

Print Name

\_\_\_\_\_

Date

\_\_\_\_\_

Witness

\_\_\_\_\_

Date