Robert J. Wester, M.D.
Fellow, American College of Obstetrics and Gynecology
Diplomate, American Board of Obstetrics and Gynecology
1960 N. Ogden Street Suite 580 Denver, CO 80218 Office: 720-287-7560 Fax: 720-287-7562

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name: ______________________ Date of Birth: ______________
Previous Name: ______________________ Phone number: ______________

THIS AUTHORIZATION APPLIES TO THE FOLLOWING INFORMATION:

☐ All my health information maintained by the above named practice
(Circle include or exclude for each of the following)
Include or Exclude: My health information related to HIV/AIDS
Include or Exclude: My health information related to drug abuse
Include or Exclude: My health information related to alcohol abuse
Include or Exclude: My health information to psychological or psychiatric conditions.
☐ My health information for the specific date(s): ______________________
☐ Other (please specify): ______________________

☐ **I authorize Dr. Robert Wester and/or Dr. Romy Mason to send a copy of my medical records to:**

☐ **I authorize Dr. Robert Wester and/or Dr. Romy Mason to request my medical records from:**

____
Name of Physician Facility Name

____
Street Address City State Zip

____
Office Phone Office Fax Email address

The purpose of this release is for: ☐ Moved ☐ Change insurance ☐ Second Opinion
☐ Changing Physicians ☐ Primary Care Physician update

This authorization will expire 90 days from the date signed. I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to authorize the above physicians to release medical information and to receive health care when the purpose is to create health information for a third party
I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Enable for me to revoke this authorization, I must write a letter to the office. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may not longer protect it.

______________________________ ______________
Patient or legally authorized individual signature Date

____
Printed Name of authorized signature