

GrassRoots Medical Clinic  
5330 Manhattan Cir. Suite C1  
Boulder, CO 80303  
Phone: (303)499-9399  
Fax: (303)499-9376

**AUTHORIZATION FOR RELEASE OF RECORDS**

Patient Name: \_\_\_\_\_  
Social Security No: \_\_\_\_\_  
Birth Date: \_\_\_\_\_  
Patient Phone Number: \_\_\_\_\_

Name of Doctor, Clinic, Hospital or other Medical  
Provider: \_\_\_\_\_  
Medical Provider Phone Number: \_\_\_\_\_  
Medical Records Department Fax Number: \_\_\_\_\_

I, \_\_\_\_\_ (patient name) authorize the above named medical  
provider to furnish medical information concerning the above-named patient to  
**GrassRoots Medical Clinic**.

This medical information is to be **limited to the following**:  
Treating provider's notes and reports including history of illness, objective findings,  
diagnosis and treatment for the following  
condition(s): \_\_\_\_\_  
\_\_\_\_\_

(It is not necessary to forward any information not related to the above mentioned  
condition. Thank You)  
The further use or disclosure of the authorized information by the above-named persons  
and institutions may not be accomplished without my further written consent.

Signature of patient or patient's representative: \_\_\_\_\_  
Date: \_\_\_\_\_

**ATTN: Grassroots Staff. Please contact me when my  
records arrive at \_\_\_\_\_.**  
PHONE NUMBER, E-MAIL OR ADDRESS