REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

Address:

_____

_____

Date of Birth:_____
SS#:_____

I hereby authorize and request that my records be released from: (include name of doctor you are transferring from)

Igor Huzicka, MD
5950 South Willow Drive
Suite 212
Greenwood Village, CO 80111

I hereby authorize and request that my records be released to: (include name of doctor you are transferring to)

Angelique Poturalski, MD
7261 South Broadway
Suite 101A
Littleton, CO 80122

Please indicate if you do not wish any of the following records to be released:

- Mental Health treatment records, inclusive dates _____ to _____
- Drugs and/or Alcohol dependency records
- HIV (AIDS) Antibody test results, test date _____
- HIV (AIDS) Diagnosis and treatment records, inclusive dates _____ to _____

_____ _____
Signature of patient or legal representative Date

Patients can also email **denvermd@denvermd.net** to obtain their records.
Standard charges may apply.