Littleton Wellness Center

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Bruce Dorr M.D.
Kelle Oberle M.D.
Shelbie Paul NP
Suzanne Kimble NP
Lynn Mason NP
Lydia Landusky NP

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name:_____ Date of Birth:_____

Phone Number: _____

Purpose for this request: (check one)

Personal ☐ Transfer of Care ☐

Type of Records Requested: (check one)

☐ All Medical Records (as allowed by law) _____

- I Authorize the release of HIV and STD results and psych notes _____
  (Signature)

☐ Specific Information: _____

Office Name:_____

Street Address:_____ Suite #:_____

City:_____ State: _____ Zip Code: _____

Phone:_____ Fax:_____

☐ **TO SEND MY MEDICAL RECORDS TO LITTLETON OB-GYN AT THE ADDRESS ABOVE.**

☐ **LITTLETON OB GYN ASSOCIATES TO SEND MY MEDICAL RECORDS TO THE ABOVE NAMED DOCTOR'S OFFICE.**

Patient Signature_____ **Date** _____