Kristine A. Eule, M.D.
Gynecology • Obstetrics • Infertility

REQUEST FOR MEDICAL RECORDS

Patient Name: ________________________ Birthdate: ________________ SS# _______________

I hereby authorize: Name ____

Address ____

City, State, Zip ____

Phone ___________________________ Fax __________________________

To release my medical records to: Dr. Kristine A. Eule
8200 E. Belleview Ave. #414-C
Greenwood Village, CO 80111
Phone: (303) 770-0665 Fax: (303) 331-6171

Reason to release PHI: ____

Type of access requested:

_____Progress Notes
_____Pap Smear Result
_____Colposcopy Result
_____Lab Result
_____other: ____________________

_____Ultrasound Results
_____Mammogram Result
_____Prenatal (OB) Records
_____ER Notes

I acknowledge and hereby consent to such that the released information may contain alcohol, drug abuse, psychiatric, HIV result of AIDS information.

~~This release is valid until twelve months from date of signing. All records will be used solely for~~ the purpose of patient treatment, and will not be disclosed to any unauthorized parties. You, the patient, have the right to revoke this request at any time, and may do so by contacting this office.

_________________________________ Patient Signature

_________________________ Date