

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

REQUEST FOR MEDICAL RECORDS

Patient Name: _____ Birthdate: _____ SS# _____

I hereby authorize: Dr. Kristine A. Eule
8200 E. Belleview Ave. #414-C
Greenwood Village, CO 80111
Phone: (303) 770-0665 Fax: (303) 331-6171

To release my medical records to:

Name: _____
Address _____
City, State, Zip _____
Phone _____ Fax _____

Reason to release PHI: _____

Type of access requested:

<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Ultrasound Results
<input type="checkbox"/> Pap Smear Result	<input type="checkbox"/> Mammogram Result
<input type="checkbox"/> Colposcopy Result	<input type="checkbox"/> Prenatal (OB) Records
<input type="checkbox"/> Lab Result	<input type="checkbox"/> ER Notes
<input type="checkbox"/> other: _____	

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