

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

_____ Ultrasound Results

_____ Pap Smear Result

_____ Mammogram Result

_____ Colposcopy Result

_____ Prenatal (OB) Records

_____ Lab Result

_____ ER Notes

_____ 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