



CONCEPTIONS
REPRODUCTIVE ASSOCIATES
OF COLORADO

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**REQUEST FOR MEDICAL RECORDS &
PERMISSION FOR RELEASE OF INFORMATION**

PLEASE SEND THIS REQUEST FORM TO PREVIOUS PHYSICIAN FOR MEDICAL RECORDS

Records Requested from: Dr. _____
(Address) _____

_____	_____	_____	_____	_____
Last name	First name	Middle name	Maiden name	
_____		_____	_____	_____
Street address		City	State	ZIP
(____)	_____			_____
Telephone	Last name under which records may be found (if different)			Birth Date

Please send my records to (check one):

<input type="checkbox"/> Send to Littleton Clinic 271 W County Line Rd Littleton, CO 80129 Phone: 303-794-0045 Fax: 303-794-2054	<input type="checkbox"/> Send to Lafayette Clinic 300 Exempla Circle #370 Lafayette, CO 80026 Phone: 303-449-1084 Fax: 303-449-1039	<input type="checkbox"/> Send to Denver Clinic 4500 E. 9th Ave #630 Denver, CO 80220 Phone: 303-720-7887 Fax: 720-763-9140
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Please send the following items to the address checked above. Please provide a complete copy of all medical records, rather than a summary. Thank you for your time and promptness.

Records of care from _____ to _____ to include anything that could have a bearing on my fertility.

___ Medical records/operative reports ___ Laboratory reports ___ Hysterosalpingogram x-rays and reports
___ Biopsy slides ___ Other (please specify) _____

I hereby grant permission for release of these records.

_____	_____
(Name)	(Date)
_____	_____
(Witness)	(Date)

APPOINTMENT DATE _____

PLEASE RETURN A COPY OF THIS FORM WITH THE PATIENT'S RECORDS

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www.conceptionsrepro.com

271 West County Line Road Littleton, Colorado 80129 T: 303.794.0045 F: 303.794.2054	4500 E. 9th Avenue, Suite 630 Denver, Colorado 80220 T: 303.720.7887 F: 720.763.9140	300 Exempla Circle, Suite 370 Lafayette, Colorado 80026 T: 303.449.1084 F: 303.449.1039
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