Vibrant Health Clinic
1526 S. Tejon Street Colorado Springs, Colorado 80905
719.216.8367 Fax: 719.218.9779

Medical Record Request Form
Release and Authorization of Use or Disclosure
of Protected Health Information

Patient Name: _____ **Phone:**_____

Previous Name:_____

Date of Birth:_____ **Last 4 Digits of SSN:**_____

Address: _____

Previous Address: _____

I request and authorize healthcare information for the patient named above from:

Vibrant Health Clinic
1526 S. Tejon Street
Colorado Springs, CO 80905
Phone: 719-216-8367
Fax: 719.218.9779

To be released to:

Physician/Clinic Name: _____**Myself:** ___ **Other:**_____

Address: _____

Phone: _____ **Fax:** _____

Please Email Records to: _____**Or Fax to:**_____
OR Print/Mail _____
***Please note: There is a $20 admin fee to be paid in cash when you pick up your records. If you would like them mailed, there is the $20 admin fee plus the cost of mailing.**

This information is to include (please check one):

_____ **Information relating to following condition or treatment:** _____

_____ **All Healthcare Information** **Other:** _____

Patient Signature:_____**Date:**_____

This authorization will expire 1 year after the signature date. This is not a transfer of care, only a request for records for the purpose of a medical evaluation. It may take up to 60 days to fulfill your request. Thank you!