Kimberly Priebe, MD FACOG ABOG
Elizabeth Baca, MD, FACOG ABOG
Betty Lasich, MD, ABOG
Mareca Pallister, MD, FACOG ABOG
M. Brie Todd, MD
Megan M. Palmer, MD
Nancy Rhien, PA-C
Donna Howard, CNP
Mary Meuser, ANP
Aimee Birgenheier, WHCNP
In Association with Christopher J. Roach, MD FACOG ABOG

Records Release From:

Four Corners OB-GYN
#1 Mercado St. Ste: 105
Durango, CO 81301
Tel: 970-382-8800
Fax: 970-382-0122

( ) Doctor Request ( ) Patient Request ( ) Requestor ID verified ( ) Reviewed by Doctor
( ) Release Fee received ( ) Release Fee Waived ( ) Record in Log book ( ) Record in Pt file
Date Requested: ____/____/____ Date Released: ____/____/____ Release Format: ( ) Mail ( ) Fax ( ) Pick Up

( ) *Release to Patient* ( ) *Release to 3rd Party*

Please note that this form must be filled out completely. Incomplete forms will not be processed

Patient Name:_______________________________ Former name:_______________________________

Date of Birth:______/______/______ Social Security #:________-_______-________

Address:____

Phone:_____________________________ Fax:_____________________________

( ) This form releases records *FROM* Four Corners OB/GYN *TO* the below organization:

- OR -

( ) This form releases records *FROM* the below organization *TO* Four Corners OB/GYN:

3rd Party Name: ____

Address: ____

Phone: _____________________________ Fax: _____________________________

By signing I give written consent and authorize Four Corners OB-GYN to release all medical care information relating to testing, diagnosis, or treatment as specified on this form. I also understand that Federal Law protects the following information from being released along with my records unless directly specified in writing: 1) Mental or behavioral health, 2) Alcohol or drug abuse, 3) HIV and/or AIDS. In addition, I understand that I may be charged a fee to cover the processing and clerical costs incurred by the release of this information.

Signature: ____ Date:_________________________

Requestor on behalf of patient (print name):_________________________Relationship to patient:_________________________

Medical records requested: (please mark all that apply):

( ) All Medical Records ( ) Lab Reports ( ) Pathology ( ) X-Ray/Ultrasound ( ) Hospital ( ) Correspondence
( ) Other (please specify):____

Purpose for which records are being released:

( ) Changing Providers ( ) Moving ( ) Insurance Claim
( ) Worker's Compensation ( ) Legal ( ) Referral
( ) Other (please specify):____

Please note it takes 7 to 10 business days to process your request

Mercy Medical Plaza • 1 Mercado Street, Suite 105 • Durango, CO 81301
Tel 970-382-8800 • 888-866-2496 • Fax 970-382-0122 • www.fourcornersobgyn.com