

Fred Grover Jr. M.D.  
Integrative Medicine and Wellness  
360 S. Monroe St. Suite 310  
Denver, Co. 80209  
Ph: 888-726-4442, Fax 303-537-5639

**Authorization to Release Healthcare Information from Dr. Grover to another provider or hospital.**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient's Phone: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize **Dr. Fred Grover Jr. M.D.** to release my records to:

**Doctor's Name:** \_\_\_\_\_  
**Doctor's Address:** \_\_\_\_\_  
**Doctor's City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_  
**Doctor's Phone:** \_\_\_\_\_ **Fax#:** \_\_\_\_\_

The reason for this request is due to:  PCP Change  
 Other \_\_\_\_\_

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates:

\_\_\_\_\_  
 All Healthcare information

Other: \_\_\_\_\_

**Definition:** Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., including herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, nonspecific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes  No  N/A I authorize the release of my STD results, HIV testing, whether negative or positive to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes  No  N/A I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient or legally authorized

Individual's signature: \_\_\_\_\_ Date signed: \_\_\_\_\_

Release of records to patient or party other than to a consulting physician will require payment of **medical record fee of \$40** mailed to, or called in CC# to Dr. Grover's office prior to sending.  
Thank you.