

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 to Dr. Grover

Patient's Name: _____ Date of Birth: _____

Patient's Phone: _____ Social Security #: _____

I request and authorize (doctor's name) _____

Doctor's Address: _____

Doctor's City: _____ State: _____ Zip Code: _____

Doctor's Phone: _____ Fax: _____

to release healthcare information of the patient named above to:

Fred Grover Jr. M.D
360 S. Monroe St., Suite 310
Denver, CO 80209

Fax: 303-537-5639

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: _____