

**CONSENT TO RELEASE MEDICAL RECORDS  
BOULDER EYE SURGEONS**

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I hereby authorize the use or disclosure of my individual health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations.

Patient name:	Birthdate:
Address:	

From (Physician/Facility)	To (Physician/Facility)
Address:	
Phone:	Phone:
Fax:	Fax:

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form. I understand that this authorization will expire on \_\_/\_\_/\_\_ (DD/MM/YR). If I fail to specify an expiration date, this authorization will expire in 6 months. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any affect on any actions they took before they received the revocation. Any chart with more than 10 pages will be mailed.

\_\_\_\_\_  
**Signature of patient or patient's representative**

**Printed name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Relationship to the patient:**  Self  Parent  Legal Guardian