Neurology of the Rockies, L.L.C.

Patient Medical Records Request

Patient Name: _____ DOB: _____

Release to (ie: Neurology of the Rockies, Self, Current Physician, etc)

_____ Fax # _____ Phone # _____

Release from: (ie: Neurology of the Rockies, Current physician, etc)

_____ Fax# _____ Phone# _____

Range of treatment dates requested _____

Choose for which purpose: Continuing care ☐ Insurance ☐ Legal ☐ Personal ☐

What items are requested: Last 3 clinical visits ☐ EMG Report ☐ Latest labs ☐

MRI/CT report ☐ Medication List ☐ Other _____

Please fax the above requested information to 303-840-5058 (Do not send entire chart)

Patient Signature _____ Date: _____

Parent/Legal Guardian/Authorized Person _____