

MEDICAL RELEASE FORM

1. **AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION** (Please send this medical release form to your current or former health care provider)

2. **FAX Medical Records ONLY to (303) 496-6802**

3. Please list your current or former health care provider full contact information below:

Persons/organizations to release your information to:

(Donna Grandi-Nikander DNP)

Please tell us what information to release:

All Laboratory Results, Imaging Reports, Procedure Reports and Immunization Record

Release mental health, substance abuse, and/or AIDS/HIV information.

Reason(s) copies are being requested:

For Consultation and Continuity of Care

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