



Bio Identical Hormone Replacement  
Achieving Hormone Balance . . . . . Naturally

**Release of Medical Records Consent Form  
FEMALE**

Please complete and send to your physician PRIOR to your upcoming appointment. It is MANDATORY for Dr. de la Torre to have your current pap and mammogram report prior to your next hormone replacement treatment.

To: \_\_\_\_\_ Date: \_\_\_\_\_  
Your Doctor's Name

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

I, \_\_\_\_\_, authorize \_\_\_\_\_  
(Your Name) (Your Doctor's Name)

to disclose and release any individually identifiable health information related to me **from the last two years only**, which is called protected health information (PHI) under a federal health privacy law, as described below (please check all that apply):

- Mammogram Report Only
- Pap Report
- Bone Density
- Ultrasounds
- Endometrial Biopsy
- Any current hormone labs

Are there any restrictions on PHI to be disclosed: YES NO

If yes, please explain: \_\_\_\_\_

**PLEASE SEND ONLY PAPER COPIES. THANK YOU.**

Send to: Rebecca de la Torre, MD  
4450 Union Street; Suite 201  
Johnstown, Colorado  
80534  
Fax: 970-669-5348  
Phone: 970-223-0193; then press (2)

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date