CHILDREN'S MEDICAL CENTER
1625 Marion Street, Denver, CO. 80218
(303) 830-7337 Fax: (303) 830-1890

AUTHORIZATION FOR RELEASE OF RECORDS

This authorization is valid for 90 days from the date of original signature

I authorize Dr(s)________________________to release the medical records of:
(Physician or Practice Name)

Patient Name(s)________________________DOB: ____________________

________________________DOB: ____________________

________________________DOB: ____________________

To: _________________________________Telephone: ______________
(Physician or Practice Name)
Address: ______________________________Fax: ____________________
____

Please release the following information:
Immunization Records___ Most Recent Physical Exam___
Complete Clinical Records Produced in This Office Including Psych/Confidential Records___
Complete Clinical Records Produced in This Office Not Including Psych/Confidential Records___
ALL RECORDS, Including Those Sent to This Office from Previous Physicians___
(Records previously obtained from other providers could contain information that may be sensitive to you. This office may have not thoroughly read these records. We may not know whether they contain such sensitive information. Furthermore, we have no way of knowing whether the other provider released a complete copy of the record. However, by checking this box, you are authorizing us to release that information.)

I would like to request that you do NOT release information pertaining to the following (please include approximate date):____________________________
____

PLEASE INDICATE IF YOU ARE TRANSFERRING CARE YES___ NO___
If you are transferring care, we will release a copy of the record to you without charge one time. Please copy it before you give it to your new provider as there will be a charge assessed for future copies.

__________________________ __________________________ ______________
(Signature of Parent or Guardian) (Printed Name) (Date)

____
(Address)

____
(Telephone #)