**CHILDREN'S MEDICAL CENTER**
1625 Marion Street, Denver, CO 80218
Telephone Number: 303- 830-7337 Fax Number: 303-830-1890
Website: cmcpediatrics.com

**AUTHORIZATION FOR RELEASE OF RECORDS**
This Authorization is valid for one year from the date of original signature

I Authorize Dr (s) _____ to release the Medical Records of:

Patient Name(s) _____ DOB:_____

_____ DOB:_____

_____ DOB:_____

To: _____

Address: _____

Telephone Number:_____ Fax Number:_____

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 Excluding Psych/Confidential Records____

**ALL RECORDS** - Including those sent to this office from previous physicians___
(Please note that records obtained from previous providers may contain information that may be sensitive to you and that we cannot guarantee that records received are truly a complete copy. By checking this box, you are authorizing us to release all records in our possession.)

I would like to request that you do not release information pertaining to the following - Please include approximate date(s):_____

**PLEASE INDICATE IF YOU ARE TRANSFERRING CARE** YES___ NO___

If you are transferring care, we will release a copy of the medical record to you free of charge one time, future requests will incur charges.

_____ _____ _____

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

_____ _____

(Address) (Telephone Number)

~~~To Be Completed By Provider/Organization Releasing To Listed Above~~~ NON-CMC USE

**EPIC Care Everywhere Participant? ☐Yes☐NO IF your facility uses EPIC'S EHR Please provide this Patient's Epic Care Everywhere ID Number_____, and CMC will electronically extract the available PHI.**
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