

CHILDREN'S MEDICAL CENTER

1818 N Ogden St. Suite 300, 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.