

## CONSENT TO RELEASE MEDICAL RECORDS



Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

I hereby request transfer of the above patient's medical records:

FROM: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TO: Indian Crest Pediatrics  
9035 Wadsworth Pkwy #3000  
Westminster, CO 80021  
303-422-7677/Fax 303-422-6029

Reason For Request \_\_\_\_\_

Please Include:

All medical Records       History & Physical       Laboratory  
 Hospital Records       Immunization Record       Medication List  
 Problem List/Treatment       Treatment/Progress Notes

I understand that these records may include information relating to drug abuse, alcoholism, Acquired Immune Deficiency (AIDS) and psychiatric or psychological conditions and specifically authorize release of the information.

\_\_\_\_\_  
Signed (Patient if over 18 or authorized representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Relationship

### CONSENT TO RELEASE MEDICAL RECORDS NOT GENERATED IN THIS OFFICE

Records previously obtained from other providers could contain information that may be sensitive to you. The office may not have thoroughly read these records. We do not know whether they contain such sensitive information. Furthermore, we have no way of verifying whether the other provider released a COMPLETE copy of the record. However, by your signature, you are authorizing us to release that information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date