CONSENT TO RELEASE MEDICAL RECORDS

Patient Name:_____ Date of Birth_____

I hearby 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