INDIAN CREST
PEDIATRICS

CONSENT TO RELEASE MEDICAL RECORDS

Patient Name _____ Date Of Birth _____

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

From: Indian Crest Pediatrics
7975 Allison Way, Suite 100
Arvada, CO 80005
303-422-7677/303-422-6029 Fax

TO: _____

_____

_____

Email Address: _____

Reason for Transfer: _____

**** PLEASE NOTE RECORD RELEASES MAY TAKE UP TO 30 BUSINSESS DAYS FOR COMPLETION ****

Please include: _____ Summary: Medical Summary, Immunizations, Growth Chart, and Last Well Visit **OR** _____ Full Medical Record

_____ (Initial) I understand that all medical records will be provided via a HIPAA compliant DropBox Business email link.

_____ (Initial) I understand that I have provided a valid email address above for the sharing of the DropBox Business email link.

_____ (Initial) I understand that if I am providing an email that is not my own, I have confirmed the receiving party will be able to receive the records via a DropBox Business email link.

_____ (Initial) I understand that if the receiving party will not receive records via electronic means, it will be my responsibility to print and provide a paper copy.

_____ (Initial) I understand that the requested medical records will be available for retrieval for 30 days once the link is received.

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. **A copy of your photo ID is required.** This authorization will remain in effect for 12 months from the date signed unless revoked by me in writing.

_____ _____

Signature (Patient if over 18 or authorized representative) Date

_____ _____

Relationship Patient Contact Number

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 release a COMPLETE copy of the record. However, by your signature, you are authorizing us to release that information.

_____ _____

Signature Date

Interoffice only:

ID Verified _____ Records completed and verified _____
Signature/Date Signature/Date

Updated 10/06/2022

Interoffice only:

ID Verified _____ Records completed and verified _____
Signature/Date Signature/Date

Updated 10/06/2022