



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
7975 Allison Way, Suite 100
Arvada, CO 80005
Phone 303-422-7677 / Fax 303-422-6029
office@indiancrestpeds.com

Reason for Request: _____

Please include:

_____ All medical Records _____ History & Physical _____ Laboratory
_____ Hospital Records _____ Immunization Record _____ Medication List
_____ Problem List/Treatment _____ Treatment/Progress Notes
_____ Other: Please Specify _____

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.

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

Previous medical records may be sent to us using an electronic media source, such as CD or USB drive. Records received in a electronic media source will be uploaded to your child(rens) electronic health record. Please indicate below if you would like to be notified when we have completed this process so that you may pick up the media source.

_____ YES, please contact me to pick up. I can be reached at: _____

_____ NO, please dispose of the media when the files have been uploaded to the electronic health record.

This request is valid from 90 days from the date of signature.

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Updated 10/06/2022