South Metro Office: 9785 Maroon Circle St, Englewood, CO 80112 (303) 779-1172
Denver Office: 919 Jasmine Denver, CO 80220 (303) 388-4256

RELEASE OF MEDICAL RECORDS

I hereby request the release of medical record information for my child(ren):

Patient Name: _____ Date of Birth: _____/_____/_____

Patient Name: _____ Date of Birth: _____/_____/_____

Patient Name: _____ Date of Birth: _____/_____/_____

Patient Name: _____ Date of Birth: _____/_____/_____

Patient Name: _____ Date of Birth: _____/_____/_____

Transfer to/from: Release to/from:

☐ Partners In Pediatrics
919 Jasmine St.
Denver, CO 80220

_____
_____
_____

☐ Partners In Pediatrics
9785 Maroon Circle
Englewood, CO 80112

_____
_____
_____

Reason for this request for release of records: _____

_____

Records will be sent in a reasonable amount of time:

☐ I will **HAND CARRY** the records to my new health care provider.
☐ **MAIL** the medical records to the above address.
☐ **MAIL** the medical records to my home address listed below.
☐ **FAX** the medical records . Attn: _____Fax #_____

Parent/Guardian Signature: _____ Date:____/____/____

Patient Signature: _____ Date:____/____/____

NOTE: **ONLY** the patient may authorize disclosure relating to birth control, sexual disease or drug use/addiction, regardless of the age of the patient.

RELATIONSHIP TO PATIENT: _____

HOME or NEW ADDRESS: _____

CITY, STATE & ZIP CODE: _____

TELPHONE NUMBER: (_____)_____