Denver Metro Office: 3801 E. Florida Avenue, Suite 300, Denver, CO 80210 (303) 388-4256
South Metro Office: 9785 Maroon Circle, Suite G104, Englewood, CO 80112 (303) 779-1172

RELEASE OF MEDICAL RECORDS

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

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

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

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

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

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

Transfer to/from:

☐ Partners In Pediatrics
3801 E. Florida Ave.
Suite 300
Denver, CO 80210

☐ Partners In Pediatrics
9785 Maroon Circle,
Suite G104
Englewood, CO 80112

Release to/from:

_____

_____

_____

_____

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 my home address listed below
☐ **EMAIL** the medical records to_____
☐ **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: (_____) _____