Centennial Pediatrics
THE CARE THEY DESERVE

Consent to Release Medical Records

Patient Name_____ Date Of Birth_____

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

From: _____

_____

_____

To: Centennial Pediatrics
15464 E Orchard Rd
Centennial, CO 80016
Pone: 303.680.5437
Fax: 303.680.5439

Phone:_____Fax:_____

Reason for Request: ____ Permanent Transfer to New Provider

____ Consultation with: _____

____ Other: _____

I understand that the information I have agreed to release to the aforementioned party may include sensitive clinical information obtained during the dates listed below. These may or may not include treatment of substance abuse, HIV, psychiatric disorders, sexually-transmitted diseases, etc., herein excepted _____

Please include: ____ All medical records OR (check all that apply):

____Growth chart, immunizations, History, and Physical ____Medication List ____Laboratory Reports

____ Radiology Reports ____EKG Other: _____

Date range: _____to_____

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in six months from the date signed.

_____ _____
Signature (patient if over 18 or parent/guardian) Date

_____ _____
Patient relationship Contact number