

## Consent to Release Medical Records

Patient Name \_\_\_\_\_ Date Of Birth \_\_\_\_\_

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

From: Centennial Pediatrics  
15464 E Orchard Rd  
Centennial, CO. 80016  
Ph: 303.680.5437  
Fax: 303.680.5439

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 NOTE RECORD RELEASES MAY TAKE 30 DAYS FOR COMPLETION**

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

Records completed and verified by: \_\_\_\_\_ date: \_\_\_\_\_