Stapleton Pediatrics
2975 Roslyn Street * Denver, CO 80238 * Phone 303-399-7900
www.stapletonpeds.com

Pearl Street Pediatrics
1258 S Pearl Street * Denver, CO 80210 * Phone 303-399-7970
www.pearlstreetpeds.com

Authorization of Release Medical Records/ Information

Patient Name/s _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

Release Records for (please check one): Referral Specialist: ☐ Transferring Care: ☐ Personal Use: ☐

From: _____ TO: _____

Pearl Street Pediatrics
1258 S Pearl Street
Denver CO 80220

Phone Number: 303-799-7970
Fax Number: 303-399-7905
EMAIL: Forms@stapletonpeds.com

From: _____ TO: _____

Stapleton Pediatrics
2975 Roslyn St # 100
Denver CO 80238

Phone Number: 303-399-7900
Fax Number: 303-399-7999
EMAIL: forms@stapletonpeds.com

From: _____ TO: _____

Name of facility: _____
Address: _____
_____
Phone Number: _____
Fax Number: _____

I request and authorize the above office or facility to release ALL medical records to the person or entity listed above. I understand that the information to be released may include, but is not limited to, the following conditions: drug abuse, alcohol abuse or alcoholism, sickle cell anemia, psychological or psychiatric conditions, AIDS or HIV status, and past medical history.

I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulation

I certify that this request has been made voluntarily and I can refuse and/or revoke this authorization in writing at any time, except to the extent that an action has already been taken to comply with it.

I understand this authorization will expire 60 days after the date signed. During this period, this release may be revoked by written notice.

We attempt to complete all records release requests within 5 – 10 business days.

Reason for leaving: _____

Printed name of Patient (or Guardian)_____
Signature of Patient (or Guardian if a minor)_____
Date Signed:_____

OFFICE USE ONLY: Received date/time: _____ By: _____