



# Stapleton Pediatrics

## 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: \_\_\_\_\_ **Stapleton Pediatrics** Phone Number: 303-399-7900  
**2975 Roslyn St # 100** Fax Number: 303-399-7999  
**Denver CO 80238** 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.

**Stapleton Pediatrics attempts to complete all records release requests within 5 – 10 business days.**

Reason for leaving Stapleton Pediatrics: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Printed name of Patient (or Guardian) \_\_\_\_\_

Signature of Patient (or Guardian if a minor) \_\_\_\_\_

Date Signed: \_\_\_\_\_

**OFFICE USE ONLY:** Received date/time: \_\_\_\_\_ By: \_\_\_\_\_