STAPLETON PEDIATRICS

Authorization to Release Medical Records/Information

Patient Name/s _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

Release Records ____ **FROM** ____ **TO** Release Records ____ **FROM** ____ **TO**

_____

_____

_____

_____

Stapleton Pediatrics, P.C.
2975 Roslyn St, Suite 100
Denver, CO 80238
Phone: 303-399-7900
Fax: 303-399-7999

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 regulations.

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, without my express revocation, either one year after the date of signing, or if I am a minor, on the date I become an adult according to state law, whichever occurs first.

Signature of Patient (or Guardian if a minor) _____

Printed name of Patient (or Guardian) _____

Date signed: _____