

**MEDICAL RECORDS RELEASE FORM**  
**AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION**

To Medical Provider:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

State/Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

Patient's Name & Address:

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Phone #: \_\_\_\_\_

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**RELEASE TO:**      **Crown Point Pediatrics**  
                         **Dr. David Roos and Dr. Jason Kalan**  
                         **9235 Crown Crest Blvd #100**  
                         **Parker, CO 80138**  
                         **Phone: (303) 695-7667      Fax: (303) 695-8146**

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*I request and authorize the release of information to the organization, agency, or individual named above and understand that the information to be released may include the following conditions(s):*

1. Drug abuse/alcohol abuse (Federal Regulation 42 C.F.R., Part 2).
  2. Psychological or psychiatric conditions.
  3. A test for the presence of antibodies (HIV) virus which causes AIDS.
  4. An AIDS diagnosis and/or AIDS related condition.
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**INFORMATION REQUEST – We only desire the necessary records (see instructions)**

1. If the above patient was a well child/person, SEND ONLY the shot record, drug allergies, date of last well care, and current medications.
  2. Send a copy of patient's growth chart.
  3. If the patient has a CHRONIC OR ONGOING DISEASE, send the appropriate records, consults, laboratory results, and radiographic evaluations for this particular illness.
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*I certify that this request has been made voluntarily. This authorization is subject to written revocation at any time, except to the extent that action has already been taken to comply with it. In any event, this authorization expires ninety days from the date of signature. I release the above named from liability and claims of any nature pertaining to the disclosure of requested information contained in my medical records.*

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date