

**MEDICAL RECORDS RELEASE FORM**

**AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION TO CROWN POINT PEDS**

To (Medical Provider who is to release records):

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

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

\_\_\_\_\_

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

Fax #: \_\_\_\_\_

Patient Info:

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 from the organization, agency, or individual named above and understand that the information to be released may include the following condition(s):

1. Drug/ alcohol abuse (Federal Regulation 42 C.F.R, Part 2)
2. Psychological and psychiatric conditions
3. Tests for the presence of antibodies (HIV)/ virus which causes AIDS.
4. An AIDS diagnosis and/or AIDS related conditions

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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, last well care, growth chart and current medications
2. If the patient has a CHRONIC OR ONGOING CONDITION/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 in the event that action has already been taken to comply with it. In any event, this authorization expires ninety (90) 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/ Patient (18yrs and up)

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date