Pediatric Associates, Prof, LLC
947 South 5th
Montrose, CO 81401
970-249-2421 (office)
970-249-8897 (fax)

MEDICAL RECORDS RELEASE FORM

RELEASE FROM	Doctor Name	**RELEASE TO**	Doctor Name
	Address		Address
			City, State Zip
	Phone/Fax		Phone/Fax

I authorize the release of records for the following:

Child's Name	Date of Birth
1.	
2.	
3.	
4.	
5.	
6.	

Reason(s) for this authorization (check all that apply): ☐ at my request or ☐ other (specify)_____

Covering the periods of service from: Birth to Present or Date of Service _____ to _____

Only records generated through The Pediatrics will be released. **(This does not include records from outside sources.)**

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

1. Drug abuse/Alcohol abuse (federal regulation 42 C.F.R., Part 2)
2. Psychological/Psychiatric conditions
3. A test for H.I.V. (A.I.D.S.) virus
4. An A.I.D.S diagnosis and or A.I.D.S. related condition(s).

****** Medical Record Charges: (can occur if applicable)**
According to Colorado Statutes (GCCR 1101-1,Rule XIV) there is a charge for copies of medical records. The charge is $14.00 for the first 10 pages, $.50/page for pages 11-39, and $.33/page for pages 40 and above.

I hereby release The Pediatric Associates and personnel from all legal responsibility and liability that may arise from the records released that I have authorized above. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Office Manager.

This authorization is valid from one year from the signature date unless otherwise noted here_____.

_____

Signature of Parent or Guardian Date Signed Relationship to Patient

_____

Address of Above Parent or Guardian Phone # of Above Parent or Guardian

PLEASE ALLOW 7-10 BUSINESS DAYS TO PROCESS