AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

Physician or Facility to provide records: Pediatric Endocrine Associates Phone: 303-783-3883
8200 E. Belleview Ave #510-E Fax: 303-783-3800
Greenwood Village, CO 80111

Patient Name: _____ **SSN:** _____ **DOB:** _____

Person/Facility to receive records:
(Name, address, phone, fax) _____
_____
_____
(____)_____(____)_____

I authorize the health care provider to release the information specified below to the organization, agency, or individual named on this request.

Release these records: **Initials**

1. All records generated by this facility..... _____
   OR
2. Only the dates of service or labs specified..... _____

Please specify: _____

I understand that I may revoke this authorization at any time. A copy of this authorization may be utilized with the same effectiveness as an original. **I understand that there may be a copying fee per the Colorado Department of Public Health and Environment.**

Patient signature: _____

Maiden Name: _____

Date: _____

Person authorized to sign for patient: _____

Signature: _____

Relationship to patient: _____

Date: _____

Reason for release:
☐ Moved/Moving
☐ Insurance Change
☐ Other (please specify) _____

Are you transferring care? Yes ☐ No ☐

MEDICAL RECORDS FEES

TURN AROUND TIME FOR ALL FORMS is 2 – 5 DAYS

- Standard Daycare form – No Charge
- School / Camp form. Forms to be filled out by parent or guardian and then signed by Provider – No Charge
- Family and Medical Leave (WH-380) and other non standard forms – $15.00
- Copy of Medical Records to be faxed, mailed, or picked up- see below:
- Complete copy of medical records $15.00 first 20 pages, pages 21-25 are $0.50/page and pages 25 and over are $0.33/page