**Clifford A. Bloch, MD, FAAP**
Pediatric Endocrinologist
**Sunil Nayak, MD, FAAP**
Pediatric Endocrinologist
**Alicia G. Marks, DO**
Pediatric Endocrinologist
**Nicole M. Rotter, CPNP, CDE**
**Jean Bessey, MPH, RD, CDE**

# AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

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

**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.**

Person authorized to sign for patient:

Patient signature: ______________________ ______________________

Maiden Name: ______________________ Signature: ______________________

Date: ______________________ 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 2-30 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 per page and pages 25 and over are $0.33 per page