

Greenwood Pediatrics, P.C.

RECORDS RELEASE AUTHORIZATION

I authorize _____ to release protected health information to
(please circle the correct office below):

Phone # _____ Fax # _____

Southeast

9094 E. Mineral Ave. #100
Centennial, CO 80112
303-694-3200
fax# 303-694-2680

Southwest

10901 W. Toller Dr., Suite #101
Littleton, CO 80127
303-973-3200
fax # 303-904-8510

Parker

16830 Northgate Dr. #150
Parker, CO 80134
303-805-7879
fax # 303-805-8076

Please send a copy of the entire medical record, including but not limited to, immunization status, growth and developmental information, office notes, consult notes and those items marked below with my initials for each child listed.

Drug abuse, if any

Alcohol abuse, if any

Psychological or psychiatric conditions, if any

AIDS/HIV, if any

Child's name and date of birth: _____

Parent's name: _____

Address: _____

Phone number: _____

Signature: _____ Date: _____

This Authorization will expire 90 days after the date identified above. You can cancel this authorization at any time, but you must do so in writing. If you cancel it, the people authorized to use and disclose your protected health information may use the information collected prior to the date you revoked this authorization. Please send written revocation to the individual or department who you authorized to use your protected health information. Also, please be aware that once we disclose this information per your instructions, the information is subject to re-disclosure and may no longer be protected.

NOTE: WHEN THIS FORM IS COMPLETED, PLEASE DO NOT SEND IT TO GREENWOOD PEDIATRICS. MAIL THIS FORM TO YOUR PREVIOUS DOCTOR TO HAVE THE RECORDS COPIED AND SENT TO OUR OFFICE. THANK YOU.