CONSENT FOR RELEASE OF MEDICAL INFORMATION

On this day _____, I request and authorize that a complete copy of the medical records including doctor notes, growth charts, immunization records, laboratory and radiology reports, specialist reports and other material regarding medical consultations and treatment for patient:

First _____ Middle _____ Last _____

Date of Birth _____

I understand that information disclosed pursuant to this authorization may include information relating to sexually transmitted disease, HIV/AIDS, treatment for alcohol and drug abuse (protected by Federal Law, 42 CFR, Part 2), and psychological or psychiatric conditions unless restricted as follows:

_____

_____

I understand that this authorization will expire, without my express revocation, **60 days** from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.

I also understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. Lakeside Youth N Kids Pediatrics cannot condition treatment, payment and enrollment in the health plan or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Parent/Patient requesting information:

_____

Print name *Signature* *Date*

Parent/Patient phone number: _____

Parent/Patient address: _____

Records requested from (name of dr.): _____

Address: _____

Phone: _____ Fax: _____

Please accept this signed consent form as authorization for the release of medical information regarding the above patient to be forwarded to:

Lakeside Youth N Kids Pediatrics 6055 W 46th Ave., Ste. A – Wheat Ridge, CO 80033

Phone: 303-423-8017 Fax: 720-639-6894