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Denver, CO 80249

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Records Requested By:

Patient's Name:	Patient's Date of Birth:
Parent's Name:	Parent's Phone Number:

Records Requested to be Sent to:

Medical Practice or Physician Name:	
Medical Practice or Physician Phone:	Medical Practice or Physician Fax:
Please release and send ALL medical records for this patient, unless noted otherwise:	

Consent & Authorization:

By signing below, I consent that I have read and understand the following and authorize the entity named above to release medical records by Prairie Pediatrics to the practice/physician listed above.

1) This authorization is strictly voluntary, and my continued treatment is not conditioned upon signing this authorization.
2) I can revoke this authorization anytime in writing, but if I do, it will not have any effect on prior releases of information.
3) If this request is submitted to an entity that is not a non-healthcare provider or plan, the information may no longer be protected by federal law and may be re-disclosed.
4) Prairie Pediatrics is not responsible for unauthorized access to your PHI, or any other risks associated with this request.
5) I acknowledge that the released information may contain sensitive PHI and hereby consent to the release of such information.

Signature of Patient/Patient's Representative:	Date:
Name of Representative:	Relationship to Patient: