Park View Pediatrics
6179 S Balsam Way Suite 205 Littleton, CO 80123
Office: (303)972-2000 | Fax: (720)245-2690

CONSENT TO RELEASE MEDICAL RECORDS FROM US

Patient name:_____ Date of birth:_____
Patient name:_____ Date of birth:_____
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Patient name:_____ Date of birth_____

FROM: Park View Pediatrics, PLLC
6179 S. Balsam Way, Suite 205
Littleton, CO 80123

TO:_____
_____
_____

We will complete your child's records request within 14 business days. The basic records will include; immunizations, growth charts, and the last Well Child Check. There is a $15 fee for an entire chart. Additional charges may apply for charts over 25 pages. Payment must be made before records are mailed or picked up.

Please check the appropriate box below.

_____ I would like a copy of the entire chart. Including those items marked below with my initials, for each child listed. I understand there is a $15.00 fee for each chart and additional charges may be applied if over 25 pages, per chart.

_____ Please send basic records only. No fees will be assessed.

_____ Please fax my chart to the above stated medical practice. No fees will be assessed

Sensitive Information: I recognize that these records may contain sensitive information relating to substance abuse, HIV or Auto Immune Deficiency Disorder/AIDS, sexual information, psychiatric or psychological conditions and specialists notes. I specifically authorize release of this information. I hereby request release of the following:

___Substance Abuse, if any
___Psychological or Psychiatric conditions, if any
___Specialist Records, if any/available
___AIDS/HIV, if any

In order for us to provide the best service to our patients, please tell us why you have chosen to leave Park View Pediatrics.

___ Moved from the area
___ Change of Insurance
___ Dissatisfied. Please provide reason:

_____
_____

SIGNED: _____
Parent or Guardian's name_____
Patient relationship: _____
Date _____

Date processed in office:_____
Initials of office personnel _____