Rose Pediatrics
Our Family Caring For Your Family

Patient information

Patient Name	Last:	First:	Middle initial:	
Patient DOB				
Parent/Guardian Name				
Patient Address				
Parent/Guardian Phone Numbers				

Records to be released FROM

Practice/Provider Name		
Address		
Phone Number		Fax Number:

Records to be released TO

Practice/Provider Name		
Address		
Phone Number		Fax Number:

Reason for Release (please check one)		**Information to be released** (please check one)	
	Changing Offices		Entire chart
	Change of Insurance		Labs/X-rays only
	Moving out of State		Consult notes only
	Other (please explain):		Other (please explain):

Acknowledgement: I request and authorize the above-named doctor or health care provider to release the information specified above to the organization, agency, or individual named on this request. I understand that the information to be released may include information regarding the following condition(s):Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), Sickle Cell Anemia, and Psychological or psychiatric conditions, if any.
NOTICE TO WHOMEVER DISCLOSURE IS MADE: This information is from records whose confidentiality is protected by federal law. Federal regulations (42 CRF Part 2) prohibits any further disclosure of this information without the specific written consent of the person to whom is pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

My authorization is given freely with the understanding that:

- I may revoke this authorization at any time. Except where information has already been released in reliance on my authorization, provided that my revocation is in writing
- This authorization is valid for a **60 day** period from the date it is signed or sooner if so specified by me, as indicated above.
- Rose Pediatrics will not change my treatment because of this signed authorization.
- A photocopy or fax of this authorization is as valid as the original.
- Rose Pediatrics, its directors, officers, employees, agents and volunteers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- A fee may be incurred for fulfillment of authorization. In the case of continuity of care or personal copy to patient, we may transfer a minimal portion of your records (up to 20 pages) as a courtesy for free. We reserve the right to charge the medical records state fee structure as set forth in the state statue for larger requests, request for older records, or to specific requestors.
- I will be given a copy of this signed authorization by request.

Expiration: Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 60 days from the date hereof, unless otherwise specified: _____Date (must not exceed 1 year).

Signature of Parent/Guardian	
Relationship to Patient	
Date Signed	

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P. 303.320.7366 F. 303.320.7367

Highlands Ranch Office
9137 Ridgeline Blvd., Suite 130, Highlands Ranch, CO 80129
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