CONSENT FOR RELEASE OF MEDICAL INFORMATION

Records released from: Lakeside Youth N Kids Pediatrics
6055 W. 46th Ave., Ste. A
Wheat Ridge, CO 80033 303-423-8017 Fax: 720-6396-6894

I would like to request that a copy of the following medical information be forwarded to:
Name:_____
Business:_____
Address:_____
City:_____State:_____Zip:_____
Telephone#:_____Fax#:_____
Email of office:_____
Reason for information request:_____

Date:_____Date needed:_____(Please allow at least 1 week)

The copied records are sent in a encrypted email. We do not print/mail or fax these records.

Should we email them or do you want to pick them up?_____
If you, as the parent pick them up it is a $25.00 fee.
Do you want complete copy of Chart?_____

Please mark below only if you don't want entire chart:.
Medical Summary, last check up and Immunization records:_____
Office Visits with specific date range of:_____
Records regarding specific condition of:_____
Laboratory reports- All Reports:_____Specific Reports:_____
Radiology reports – All Reports:_____Specific Reports:_____
Immunizations only: _____
Billing History – All Dates:_____Specific Dates:_____

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: _____
_____

The records should be under the following name:

First Middle Last Date of Birth

Parent / Patient requesting records: **Print** _____**Signature**: _____

Please provide separate consent form for each child. There is no charge for one copy of records sent to a health care provider; any additional copies will be a $25.00 charge per chart. Please allow up to 10 business days for us to get the records transferred.

Authorization valid for 60 days only!