

ARVADA PEDIATRIC ASSOCIATES, PC  
3830 W. 121<sup>st</sup> Place, Broomfield, CO 80020  
Phone 303-410-8041  
Fax 303-410-8044

**Consent for Release of Medical Information  
FROM Arvada Pediatric Associates, PC**

Patient Name(s):

Date of birth:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby consent to the release of medical information for the above-named patient(s) to the following health care provider:

Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

Information to be released:

Problem list, growth chart, immunization record (usually available in 3-5 days)

All health information (may require up to 30 days)

Only those records specified as follows:

**IF PATIENTS ARE 13YRS OR OLDER, THEY MUST SIGN FOR THE FOLLOWING:**

I specifically consent to the release of information relating to:

Substance abuse (including drug/alcohol abuse)

Mental health (including psychotherapy notes)

Sexually transmitted diseases and HIV related information

Contraception and pregnancy counseling/evaluation

Signature: \_\_\_\_\_ Name: \_\_\_\_\_

Purpose of disclosure: \_\_\_\_\_ Changing physicians

\_\_\_\_\_ Consultation \_\_\_\_\_ Other (please specify) \_\_\_\_\_

1. I understand that this consent will expire 60 days after the date I have signed this form.
2. I understand that I may revoke this consent at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that I am not required to sign this consent and that the organization to which this information is released may not condition treatment or coverage on my providing this consent, except as may be permitted by law.
4. I understand that information used or disclosed pursuant to this consent may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations.

\_\_\_\_\_  
Signature of patient or authorized representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
PRINT authorized representative name

\_\_\_\_\_  
Relationship to patient