ARVADA PEDIATRIC ASSOCIATES, P.C.
3830 W. 121st Place, Broomfield, CO 80020
Phone: 303-410-8041
Fax: 303-410-8044

Consent for Release of Medical Information

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: (please check one)

☐ **Arvada Pediatrics**
8030 Lee Drive
Arvada, CO 80005
Phone: 303-421-6873
Fax: 303-421-9922

☐ **Arvada Pediatrics-North**
3830 W. 121st Place
Broomfield, CO 80020
Phone: 303-410-8041
Fax: 303-410-8044

Information to be released:
☐Problem list, growth chart, immunization record
☐All health information
☐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