LITTLETON PEDIATRIC MEDICAL CENTER

Medical Record Release

LITTLETON PEDIATRIC MEDICAL CENTER

I request that my children's medical records be transferred to Littleton Pediatric Medical Center from:

Name: ____

Address: ____

City: ____________________ State: __________ Zip: ____________

Person Making Request	**Child's Name**	**Date of Birth**
______________________	______________________	
Print name		
______________________	______________________	
Signature Date	______________________	
New Address if Applicable:	Reason for leaving ____________	
______________________		
______________________		
______________________	Patients age 18 years and older must sign this Release on their own behalf.	

Release these records: Initials

1. Only records generated by this facility (not including records received from other sources) ______
2. Only some portion of records maintained at facility (specify below) ______
3. All medical records at this facility ______

Expiration or revocation of authorization -- I understand that I may revoke this authorization at any time. Use of copies-- A copy of this authorization may be utilized with the same effectiveness as an original. I release the above named from any liability and claims of any nature pertaining to the disclosure of requested information contained in the medical records. I do acknowledge that in accordance with the Joint Bar Association/Medical Society Committee a fee will be charged for copies of medical records. This release expires 6 months after date signed.

Thank You
Medical Records Department
Fax 303.791.7756