LITTLETON PEDIATRIC MEDICAL CENTER

Medical Records Release to 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 Code: ________

PERSON MAKING REQUEST	CHILD'S NAME	DATE OF BIRTH
Phone No.: ______________	______________	______________
______________ Print Name	______________	______________
	______________	______________
______________ Signature	______________	______________

Patients age 18 and older must Sign this release on their own behalf

____
Date

New Address if Applicable:

____

____

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____

Reason for Leaving: ______________

____

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 of 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 the copies of medical records. This release expires 6 months after date signed.

Thank you,
Medical Records Department
Fax: 303-791-7756