Complete Care Pediatrics

# Request to Release Medical Records

**FROM**
**PROVIDER :** _____

**ADDRESS:** _____

**PHONE:** _____ **FAX:** _____

Please release medical records for:

**Patient Name:** _____ **Date of Birth:** _____

**Patient Name:** _____ **Date of Birth:** _____

**Patient Name:** _____ **Date of Birth:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip** _____

Please mail or fax records to:

**COMPLETE CARE PEDIATRICS**
2801 Youngfield St Suite 120
Golden, CO 80401
Phone: (720) 807-4304
Fax: 1-833-771-2215
info@completecarepediatricsco.com

Because the patient is younger than age 18, the signature below serves as authroization for release of records.

_____
Print Parent/Guardian Name

_____ _____
Authorized Signature Date