Sunflower Pediatrics, PC
12500 West 58th Ave, Ste 213
Arvada, CO 80002

Authorization to Release Medical Records/Information

Patient Name ____ Birth Date:__________________
Patient Name ____ Birth Date: ________________
Patient Name ____ Birth Date: ________________
Patient Name ____ Birth Date:: ________________

Release Records ____ **FROM** ____ **TO**
____
____
____
____

Release Records ____ **FROM** ____ **TO**
Sunflower Pediatrics, PC
12500 West 58th Ave, Ste 213
Arvada, CO 80002

I request and authorize the above office or facility to release **ALL** medical records to the person or entity listed above. I understand that the information to be released may include, but is not limited to, the following conditions: drug abuse, alcohol abuse or alcoholism, psychological or psychiatric conditions, AIDS or HIV status, and past medical history.
I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. When and if possible, medical records may be transmitted electronically.

I certify that this request has been made voluntarily and I can refuse and/or revoke this authorization in writing at any time, except to the extent that an action has already been taken to comply with it.
I understand this authorization will expire, without my express revocation, either one year after the date of signing, or if I am a minor, on the date I become an adult according to state law, whichever occurs first.

Signature of Patient (or Guardian if a minor) ____
Printed name of Patient (or Guardian) ____
Date signed: ____________________________