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**DO NOT RETURN THIS FORM TO PARKER PEDIATRICS,
 IT NEEDS TO GO TO THE PREVIOUS PROVIDER**

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Former Physician:	
Name of Physician/Practice	
Address	
Telephone/Fax	
<p>I have transferred my child(ren)'s medical care to the practice below and hereby request that my child(ren)'s medical records be sent to:</p> <p>Parker Pediatrics & Adolescents, P.C. 10371 Parkglenn Way, Suite 100 Parker, CO 80138</p>	
Effective Date of Release	
Patient Name	Date of Birth
If you require a different form in order to transfer these records, please send to:	
Patient's Present Address	

I understand that the information to be released may include the following conditions, if present: drug or alcohol abuse, psychological or psychiatric conditions, HIV or AIDS testing or diagnosis. I wish to exclude the following records from being released:

This is a one-time authorization and will expire in 60 days. During this period, this release may be revoked by written notice.

Parent's Signature		Date	
Printed Name			