The Children's Health Place
1610 29th Ave Place
Greeley, Colorado 80634
970-356-2600 Fax: 970-356-2633
www.thechildrenshealthplace.com

Consent to Access or Release Medical Records

Patient Name: _____ _____ _____
Last First MI

Date of Birth: _____ Phone: _____

Parent/Guardian: _____

☐ I request that the Children's Health Place send my records to the facility/ clinic listed below

☐ I request that the facility/ clinic listed below send my records to The Children's Health Place

Facility/ Clinic Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

____ All my health information from the above-named facility/ clinic

____ My health information relating to: _____

____ My health information for the following dates: _____

____ Other: _____

☐ I request to receive copies of medical records for my personal use. I understand that I will only receive medical record copies from the Children's Health Place no other entities. I understand that the following charges apply: $15.00 for the first 20 pages and $35.00 for the complete chart. (Refer to the Colorado Department of Health Regulations Chapter 2, part 5.2 3.4).

I understand that a signature is not required to receive healthcare services. However, I must sign this form to transfer medical information to The Children's Health Place to continue medical treatment. I may change or revoke this authorization in writing at any time. If I do, it will not affect any previous actions taken by TCHP based upon this authorization.

_____ Date: _____
Signature

_____ Relationship to Patient: _____
Print Name