Patrick J. Colletti, MD
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Patricia Landon, APRN

Authorization of Medical Records Release

I hereby authorize the use/disclosure of my child's health information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. I understand that a photocopy or fax of this authorization is as valid as the original.

Please only fax if less than 20 pages!!

Patient Name:_____ D.O.B._____

Patient Name:_____ D.O.B._____

Patient Name:_____ D.O.B._____

Records to be disclosed from:

Physician/Group:_____

Address:_____

Phone:_____ Fax:_____

Records to be released to:

Aspen Pediatrics
1001 Jones St.
Reno, NV 89503
PH# 775-322-1880 Fax: 775-322-1897

Please circle:

All records: Certain Records:_____
Including Immunization Records
And Growth Charts

I understand that I may revoke this authorization at any time by notifying the office in writing. I also understand that the revocation will not apply to information that has already been released in response to this authorization.

_____

Signature of Parent/Legal Guardian