



Children's Eye Physicians

Kids' vision is our mission

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RELEASE OF INFORMATION-SHORT FORM
(Inspect and Copy Request Form)

TODAY'S DATE: _____

PATIENT'S NAME: _____ DATE OF BIRTH: _____

DESCRIPTION OF INFORMATION BEING REQUESTED (eg: medical records): _____

PLEASE SEND THE INFORMATION TO (include name and address): _____

ATTENTION TO: _____

REQUESTED BY (NAME): _____ RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY:

_____ REQUEST ACCEPTED. DATE INFORMATION GIVEN/SENT: _____

_____ REQUEST DENIED. REASON: _____

ACCEPTED/DENIED BY: _____ TITLE: _____

SIGNATURE: _____ DATE: _____

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9094 E Mineral Ave, Suite 200
Centennial, CO 80112

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Denver, CO 80238

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