

## Authorization/Release for Protected Health Information (PHI)

Patient Legal Name	Date of Birth	SSN
Address		Phone#
City	State	Zip Code

I hereby authorize the following facility to disclose Protected Health Information of the patient listed above

**FROM: Physician/Facility Sending Records**

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_

**TO: Receiving Entity**  
**ACADEMY PARK PEDIATRICS**  
**7373 West Jefferson Avenue, Ste. 102**  
**Lakewood, CO. 80235-2020**  
**Phone: 303-988-5252 (ext.19)**  
*Academy Park Pediatrics will NOT accept responsibility for charges incurred for records.*

Permission to Release Protected Health Information \_\_\_\_\_

Type of Access Requested: \_\_\_\_\_ Specific Date Range Requested: \_\_\_\_\_ Last 2 years of visits \_\_\_\_\_

<input type="checkbox"/> Copies of Records	<input type="checkbox"/> Entire Record <input type="checkbox"/> Pertinent info only <input type="checkbox"/> ER Records <input type="checkbox"/> History & Physical <input type="checkbox"/> Consult Report <input type="checkbox"/> Operative Report <input type="checkbox"/> Rehabilitation Services	<input type="checkbox"/> Lab <input type="checkbox"/> Imaging/Radiology <input type="checkbox"/> Cardiac Studies <input type="checkbox"/> Demographics <input type="checkbox"/> Nursing Notes <input type="checkbox"/> Medication Record	<input type="checkbox"/> Progress Notes <input type="checkbox"/> Physicians Orders <input type="checkbox"/> Billing Records <input type="checkbox"/> Immunizations <input type="checkbox"/> Other
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Expiration: This authorization shall expire upon (check one) *if not filled out auth will expire one year from date signed:*

Fulfillment of this request  
 Date \_\_\_\_\_

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.

I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

The facility will not condition treatment, payment, enrolment or eligibility for benefits upon authorization unless specified use applies to specific exceptions.

I understand that there may be a fee involved with the fulfillment of this request.

I have read the above and authorize the disclosure of the protected health information.

There may be a fee for copying of records. Payment is the responsibility of the patient.

Signature of Patient/Parent/LegalGuardian \_\_\_\_\_ Date \_\_\_\_\_

Printed name \_\_\_\_\_ Relation to patient \_\_\_\_\_

\* To ensure timely processing of medical records, please fill authorization out completely.\*  
You may send this release directly to your previous physician.  
 You may supply your previous physician's fax number and our office will be happy to fax this for you.