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: Facility/Doctor name
ACADEMY PARK PEDIATRICS
Attn: Medical Records
7373 W. Jefferson Ave., Ste. 102
Lakewood, CO. 80235
Phone #303-988-5252
Fax #303-988-5632

(MUST BE COMPLETE ADDRESS)
TO:
Name_____
Attn:_____
Address_____
City, State, Zip_____
Phone #_____

Fax #_____

Reason to Release Protected Health Information_____

Type of Access Requested: Specific Date Range Requested:_____ **Last 2 years of visits**_____

o Copies of Records	o Entire Record o Pertinent info only o ER Records o History & Physical o Consult Report o Operative Report o Rehabilitation Services	o Lab o Imaging/Radiology o Cardiac Studies o Demographics o Nursing Notes o Medication Record	o Progress Notes o Physicians Orders o Billing Records o Immunizations o Other

Expiration: This authorization shall expire upon (check one) *if not filled out auth will expire one year from date signed:*

- o Fulfillment of this request
- o 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. **See fee schedule below.**
I understand that the term Complete Chart for release of Protected Health Information mean that **only records generated by this facility will be released.**
I have read the above and authorize the disclosure of the protected health information.
For closed clinics there will always be a fee for copying of records.

Signature of Patient/Parent/LegalGuardian_____ Date_____

Printed name_____Relation to patient_____

Fee Schedule

Fees for duplication of Protected Heath Information shall follow the Regulations for Patient Medical Reproduction Fees of $.39 per page. Actual postage or shipping costs and applicable sales tax, if any may be charged.

*** To ensure timely processing of medical records, please fill authorization out completely.**