ACADEMY PARK PEDIATRICS, P.C.

PEDIATRIC & ADOLESCENT MEDICINE

7373 WEST JEFFERSON AVENUE • SUITE 102 • LAKEWOOD, COLORADO 80235-2020
PHONE: (303) 988-5252 • **FAX:** (303) 988-5632

4185 EAST WILDCAT RESERVE PARKWAY • SUITE 230 • HIGHLANDS RANCH, COLORADO 80126
PHONE: (303) 996-0730 • **FAX:** (303) 996-0732

Authorization/Release for Protected Health Information (PHI)

OUTGOING RECORDS RELEASE

Patient Legal Name _____ Date of Birth _____ SSN _____

Address _____ Phone# _____

City _____ State _____ Zip Code _____

I hereby authorize Academy Park Pediatrics to disclose Protected Health Information of the patient listed above

Reason to Release Records _____

For example: Moving, Transfer to another physician, personal use, insurance request, etc.

TO: Provider Name/Name of Organization _____

Street Address _____ **City** _____

State _____ **Zip** _____ **Phone** _____ **Fax** _____

o Last 2 years o Last 5 years **OR** Specify what records are needed	o WCC/last 3 visits o Growth Charts o Immunizations o Progress notes/sick or injury visits-2 yr o Meds List	o Lab o Imaging/Radiology Reports o Other/specify if request is for one issue/one DOS:_____ (example:auto accident issue)	o **Non Clinical:** o Billing Records 12 months-includes diagnoses and procedure codes

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_____

Please send records as noted above

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 in writing 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, enrollment 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.

Payment of fee for copying and mailing records is the responsibility of the patient.

Fee Schedule

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

Signature of Patient/Parent/LegalGuardian_____ Date_____

Printed name_____ Relation to patient_____

Best phone number to reach you with questions/problems fulfilling this request_____

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