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
4185 E.Wildcat Reserve Pkwy,Ste 230
Highlands Ranch, CO. 80126
Phone: 303-996-0730
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**_____

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.
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.