PEDIATRICS 5280, PC

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION FROM PEDIATRICS 5280

Patient Legal Name(s) _____ Date(s) of Birth _____

Address _____ City _____ State _____ Zip _____ Phone Number _____

I hereby authorize Pediatrics 5280 to disclose Protected Health Information of the patient(s) listed above.

From:
Pediatrics 5280
9094 E. Mineral Ave #120
Centennial, CO 80112
Phone: 303-779-5437
Fax: 303-689-9628

To:
Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Reason to Release Protected Health Information:

_____ Transfer of Primary Care _____ Referral to Specialist _____ Insurance _____ Personal

Type of Information to be released:

_____ Copy of Records from June 2009 to Present

_____ Summary of Entire Chart (Growth Chart, Problem List, Immunizations)

_____ Health Information related to the following treatment, condition and/or date(s): _____

- I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, sexual activity, HIV results and/or AIDS information.
- I understand that the term "Chart" for release of Protected Health Information means that **only records generated by this facility will be released.**
- 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.
- I understand that there may be a fee involved with the fulfillment of this request. **See Fee Schedule below.**
- I have read the above and authorize the disclosure of the Protected Health Information. **This release expires 90 days from signature date.**

_____ _____

Signature of Patient/Parent/Legal Guardian Date

Fee Schedule

Fees for duplication of Protected Health Information shall follow the Regulations for Patient Medical Reproduction Fees 6 C.C.R. 1011-1, Chapter 2, Part 5.2.3.4. which states the patient shall pay for the reasonable cost of obtaining a copy of his/her patient record, not to exceed $14.00 for the first 10 or fewer pages, $.50 per page for pages 11-40, and $.33 per page for every additional 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.**