

**Authorization/Release for Protected Health Information (PHI)
Records Furnished by CCI**

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

I hereby authorize **Academy Park Pediatrics** 7373 W Jefferson Ave #102 Lakewood, CO 80235 to disclose Protected Health Information of the patient listed above. **Please mail completed release to Academy Park Pediatric or fax 303-988-5632**
 Requested Delivery Method: Mail Fax Pick up

To: _____
 Name/Title _____
 Address _____

 Phone # _____
 Fax # _____

Specific Date Range Requested: _____
 Most Recent Records Last 2 Years of Visits

<input type="checkbox"/> Entire Record <input type="checkbox"/> Immunizations <input type="checkbox"/> Growth Charts <input type="checkbox"/> Progress Notes <input type="checkbox"/> History & Physical <input type="checkbox"/> Consult Report <input type="checkbox"/> Operative Report	<input type="checkbox"/> Lab <input type="checkbox"/> Imaging/Radiology <input type="checkbox"/> Studies <input type="checkbox"/> Demographics <input type="checkbox"/> Nursing Notes <input type="checkbox"/> Medication Record
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Any questions please call 303-988-5252

Reason to Release Medical Records:

Expiration: This authorization shall expire upon (check one):
 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.
 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.

Signature of Patient/Parent/LegalGuardian _____ 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, and 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 ten 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.**

Credit Card Payment Information	
<input type="checkbox"/> Visa <input type="checkbox"/> Master Card	
Credit Card # _____ - _____ - _____	Exp / code # _____
Billing Zip Code for Credit card _____	Print name as it appears on Credit card _____
Contact Phone # _____	