CHERRY CREEK PEDIATRICS

4900 E Kentucky Ave. Denver, CO 80246
Phone: 303-756-0101 Fax: 303-756-1408

Authorization to Disclose Protected Health Information (PHI)

Patient Legal Name	Date of Birth	Patient Legal Name	Date of Birth
Patient Legal Name	Date of Birth	Patient Legal Name	Date of Birth

Address _____ Phone Number _____

I hereby authorize the following healthcare provider to disclose Protected Health Information of the patient(s) listed above

Transfer TO / FROM:

Cherry Creek Pediatrics
4900 E. Kentucky Ave
Denver, CO 80246

Release TO / FROM:

Name of Healthcare Provider _____

Address _____

Phone _____ Fax _____

Requested Deliver Method: Circle One Pick-up Secure Email Mail

Purpose for Release: Please Check one of the following

_____Transfer of Primary Care _____Referral to a specialist _____Parent/ Attorney/ Insurance/ Other

Reason for the release of records: _____

Records to be released:

_____Basic medical records: One year of complete medical records: Including immunization records, growth charts, and consults
_____All medical records
_____Other: Please specify _____

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

☐ Fulfillment of this request

☐ One year from date of signature

- I acknowledge that in accordance with the Federal HITECH Act, a flat fee of $6.50 will be charged for an electronic format. Per the Colorado Department of Public Health and Environment, a fee may be charged for paper copies of medical records. The charge is $14.00 for the first ten or few pages, $0.50 for pages 11-40 and $0.33 for pages 41+. Actual postage may also be charged if applicable. <u>There is no charge for physician to physician record transfers.</u>
- 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 have read the above and authorize the disclosure of the protected health information.

If patient is 18 years of age or older, the form MUST be signed by the patient.

Print Name of Parent /Legal Guardian_____ Relationship to Patient _____

Signature of Patient/Parent/Legal Guardian_____Date_____