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)

THE STATE OF		1
	**	

Patient Legal Name	Date of Birth	Patient Legal Name	Date of Birt	h	
Patient Legal Name	Date of Birth	Patient Legal Name	Date of Bir	th	
ddress Phone#					
City	State	Zip Co	de		
I hereby authorize Cherry C	reek Pediatrics to discl	ose Protected Health Informa	ation of the patient(s) l	isted above	
TO:		Requested Delivery Meth	od: Mail	Pick up	
Name/Title		Phone#	Fax#		
Address					
City		State	Zip Code		
Reason for Release					
Referral to Specialist	Transfer of Pri	mary Care Parent/	Insurance/Attorney/Ot	her	
•	-	ords unless otherwise specifi other records are available up		CC, immunization records	
Expiration: This authorizat	ion shall expire upon (o	check one):			
	Fulfillmen	nt of this request			
	One year t	from date of signature			
charged for copies \$0.33 for pages 41 record transfers. I acknowledge, and HIV results or AID I understand that th reliance upon it. The information us longer protected.	of medical records. The Actual postage may hereby consent to such information. The authorization may be seed or disclosed pursual	e Colorado Department of Pune charge is \$14.00 for the fine also be charged if applicable h, that the released information e revoked by me at any time and to the authorization may be colorate of the protected because of t	rst ten or few pages, \$0 e. There is no charge f on may contain alcoho except to the extent th e subject to re-disclosu	0.50 for pages 11-40 and for physician to physician of the physician of th	
		sclosure of the protected hea			
If patient is 18 years of ag	e or older, the form M	IUST be signed by the patie	ent.		
Print Name of Parent /Legal	Guardian				

Signature of Patient/Parent/LegalGuardian_______Date_____