Aspen Park Pediatrics, PC
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Conifer, CO 80433

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For internal use

Date Sent_____

Release of Patient Information

Patient Name:_____ **Patient Date of Birth:**_____

Address:_____ **Phone #:** _____

_____ **Email:** _____

Release to:_____ **Phone:**_____

Address:_____ **FAX:**_____

_____ **Contact**_____

Release from:_____ **Phone:**_____

Address:_____ **FAX:**_____

_____

I request and authorize the release of information to the above named recipient. I understand that the information may include the following: Drug or alcohol abuse/Psychological or psychiatric conditions/ HIV (AIDS) testing/AIDS diagnosis/records from 3rd party source such as a hospital, lab or specialist.
You may exclude certain information by checking here: ___ Drug or Alcohol abuse. ___ Psychological or psychiatric conditions. __ HIV (AIDS) testing/AIDS diagnosis.
According to Colorado Statute (GCCR 1101-1, Rule XIV), there may be a charge for copies of medical records. The releasing party may charge $14.00 for the first 10 pages, $.50/page for pages 11-39 and $.33/page for pages 40 +.

Purpose of release: _____

___X___I request the abbreviated version of the chart: Problem list, Growth charts, Immunization records.

_____I request the entire chart. (Please mark ONLY if the doctor requests the entire chart.)

Specific Date(s): (if applicable)_____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present written revocation to the releasing office. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition_____. I certify that this request has been made voluntarily. This authorization expires 90 days from the date of signature. I release the above named from liability pertaining to the disclosure of requested information. I understand any disclosure carries with it the potential for an unauthorized and federally unprotected re-disclosure.

Signature of Legal Guardian:_____**Date**_____
(if patient is a minor)
Guardian is (please check one)**:** Mother _____ Father _____ Foster parent _____ Other_____

Signature of patient:_____ **Date**_____
(if patient is a legal adult)