**Sapphire Pediatrics**

**4500 E. 9th Ave. Ste. 300**

**Denver, CO 80220**

**720-941-1778 – phone**

**720-941-1783 – fax**

**Authorization to disclose Health Information**

1. I authorize the disclosure of Health Information for the individual listed below:

Patient name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date of birth: \_\_\_\_\_\_\_\_\_\_\_ ss# \_\_\_\_\_\_\_\_\_

Medical Facility that records are requested **FROM:**

Facility Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone/fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Records disclosed **TO:**

Facility Name:\_\_\_\_Sapphire Pediatrics\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility Address: \_\_\_4500 9th Ave Suite 300\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_Denver, CO 80220\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone/fax:\_(P) 720-941-1778 (F) 720-941-1783\_\_\_\_\_\_\_\_\_

1. The type of information that you wish to be disclosed is as follows

\_\_\_ Patient health information relating to the following condition:

\_\_\_ Most recent 3 years of records

\_\_\_ Entire medical records

1. Purpose of release of medical information:

\_\_\_ continuation of care

\_\_\_ other

1. I understand that authorization for disclosure of health information is voluntary and I can refuse to sign this authorization. Treatment, payment, enrollment in the health plan or eligibility for benefits may not be conditioned on the signing of this release, except where permitted by law. I understand that any disclosure of health information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules.
2. Per Colorado Department of Public Health and Environment regulations, no fees shall be charged by a healthcare provider of patient records for requests for medical records received from another healthcare provider.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_