Pediatrics at Cherry Creek
dba Pediatrics at Stapleton Plaza

PATIENT REQUEST FOR MEDICAL RECORDS TRANSFER
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION			
PATIENT NAME			DATE OF BIRTH
ADDRESS STREET	CITY	STATE	ZIP CODE

My child has been a patient of Pediatrics at Cherry Creek and I understand that the practice has legally protected health information about him/her that I wish to transfer.

PROVIDER THAT HAS YOUR CHILD'S RECORDS

☐ Pediatrics at Cherry Creek 300 South Jackson Street, Suite 300 Denver, CO 80209 Phone: (303) 377-9663 FAX: (303) 377-9954	☐ Pediatrics at Stapleton Plaza 3401 Quebec Street, Suite 3900 Denver, CO 80207 Phone: (303) 388-4333 FAX: (303) 388-4777

PROVIDER YOU WANT TO RECEIVE YOUR RECORDS			
PROVIDER NAME			
ADDRESS STREET	CITY	STATE	ZIP CODE
PHONE	FAX		

Medical records to be released: (please check all that apply)

☐ Entire medical record (office visits, labs, radiology, medicines, immunizations)
☐ Immunization records only ☐ Mental Health ☐ Substance Abuse
☐ Billing records ☐ Other (specify): _____
☐ For treatment dates from _____ to _____

RELEASE METHOD / FORMAT REQUESTED (check one)

☐ Paper ☐ CD/DVD ☐ Fax (patient care only)

PURPOSE OF RELEASE

☐ Continuing care ☐ Transfer of care *
☐ Insurance application * ☐ Personal use or review *
☐ Litigation/legal * ☐ Social security disability determination *
☐ Other * _____

** Fees may be charged in accordance with CO Revised Statute25-1-801 and Federal Rule 45 C.F.R. §164.524(c)(4).*

- This authorization lasts for one year; however, it may be cancelled in writing at any time, but it will not affect disclosures/transfers already in progress made with this authorization.
- I can receive a copy of this authorization upon request.
- A photocopy or scanned image of this authorization may be used in lieu of the original.
- I understand that recipients may not be subject to federal law and disclose information which I have authorized them to receive.

Signature: _____ Date: _____
If patient is a minor, print name and relationship to patient:

Name: _____ Relationship: _____
Please attach a copy of documentation of personal representation, e.g., Power of Attorney, Legal Guardianship.