## **Pediatrics at Cherry Creek**

dba Pediatrics at Stapleton Plaza

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

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	PATIENT INFORMATION				
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) 377-9963 FAX: (303) 377-9954 FAX: (303) 388-4333 FAX: (303) 388-4333 FAX: (303) 388-4777  PROVIDER NAME  ADDRESS STREET CITY STATE ZIP CODE  PHONE FAX  Medical records to be released: (please check all that apply)   Children medical record (office visits, labs, radiology, medicines, immunizations)   Immunization records only	PATIENT NAME		DATE OF BIRTH		
health information about him/her that I wish to transfer.  PROVIDER THAT HAS YOUR CHILD'S RECORDS    Pediatrics at Cherry Creek	ADDRESS STREET	CITY	STATE	ZIP CODE	
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Pediatrics at Cherry Creek 300 South Jackson Street, Suite 300 Denver, CO 80209 Phone: (303) 377-9663 Phone: (303) 377-9954    Pediatrics at Stapleton Plaza   3401 Quebec Street, Suite 3900   Denver, CO 80207   Phone: (303) 377-9954   Phone: (303) 377-9954   PROVIDER YOU WANT TO RECEIVE YOUR RECORDS   PROVIDER NAME   ADDRESS STREET					
300 South Jackson Street, Suite 300 Denver, CO 80209 Phone: (303) 377-9663 FAX: (303) 377-9954 PROVIDER YOU WANT TO RECEIVE YOUR RECORDS PROVIDER NAME  ADDRESS STREET CITY STATE DIP 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.	PROVIDER THAT HAS YOUR CHILD'S	RECORDS			
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Billing records	☐ Entire medical record (office visits, labs, radiology, medicines, immunizations)				
For treatment dates from	☐ Immunization records only ☐ Mental Health ☐ Substance Abuse				
For treatment dates from	☐ Billing records ☐ Other (specify):				
RELEASE METHOD / FORMAT REQUESTED (check one)    Paper	***				
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Signature: Date:					
Signature: Date:	authorized them to receive.				
If patient is a minor, print name and relationship to patient:	Signature:	Da	te:		
	If patient is a minor, print name and rela	ntionship to patient:			
Name: Relationship:	Name:	Dal	ationship		

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