AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) FROM PEDIATRICS AT CHERRY CREEK

Patient Legal Name(s)	1) 2) 3) 4) 5) 6)			**Date(s) of Birth**	1) 2) 3) 4) 5) 6)
Street Address		**City**	**State**	**Zip**	**Phone Number**

I attest that I am the legal guardian for the above patient(s) and I hereby authorize Pediatrics at Cherry Creek to disclose Protected Health information of the patient(s) listed above to the following entity:

From:	**To:**
Pediatrics at Cherry Creek LLC 300 South Jackson Street, Suite 300 Denver CO 80209 Phone: 303-377-9663 Fax: 303-377-9954 Email: info@pedsatcc.com	Name: _____ Address: _____ _____ Phone: _____ Fax: _____ Secure Email: _____

Reason to Release Protected Health Information:

❑ Transfer of Primary Care ❑ Referral to Specialist ❑ Insurance ❑ Personal

Type of Information to be released:

❑ Copy of Records from 2015 to Present

❑ Summary of Entire Chart (Growth Chart, Problem List, Immunizations)

❑ Health Information related to the following treatment, condition and/or date(s):

_____

- I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, sexual activity, HIV results and/or AIDS information.
- I understand that the term "Chart" for release of Protected Health Information means that only records generated by Pediatrics at Cherry Creek will be released.
- I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.
- The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
- I understand that there may be a fee involved with the fulfillment of this request. See Fee Schedule below.
- I have read the above and authorize the disclosure of the Protected Health Information. This release expires 90 days from signature date.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

Fee Schedule

Fees for duplication of Protected Health Information shall follow the Regulations for Patient Medical Reproduction Fees 6 C.C.R. 1011-1, Chapter 2, Part 5.2.3.4. which states the patient shall pay for the reasonable cost of obtaining a copy of his/her patient record, not to exceed $14.00 for the first 10 or fewer pages, $.50 per page for pages 11-40, and $.33 per page for every additional page. Actual postage or shipping costs and applicable sales tax, if any may be charged.

***To ensure timely processing of medical records, please fill authorization out completely.**