



3555 Lutheran Pkwy, Suite 200, Wheat Ridge, CO 80033
 Phone: (720) 284-3700 Fax: (303) 467-0525
 13402 West Coal Mine Ave, Suite 200, Littleton, CO 80127
 Phone: (303) 973-9300 Fax: (303) 973-9308
Medical Records/Referrals
Fax: (303) 431-1038

Authorization/Release for Protected Health Information (PHI)

PATIENT'S Legal Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

I hereby authorize the following facility to disclose Protected Health Information of the patient listed above.

Requested Delivery Method: MyChart (**Complete Set** of Records/Never Expire) To **SIGN UP**, Call 720-777-4357
 Pick Up Fax Directly to New Provider (shot record, growth chart, last WCC **ONLY**)

Facility and/or Dr's Name

| |
|----------|
| From: |
| Dr Name: |
| Address |
| Phone #: |
| Fax #: |

| |
|----------|
| To: |
| Dr Name: |
| Address: |
| Phone #: |
| Fax #: |

Reason for Transfer: _____

Type of Access Requested:

Specific Date Range Requested:

| | | | |
|--|-----------------------|--|---|
| Abbreviated Records: <input type="checkbox"/> Last Well Exam <input type="checkbox"/> Growth Chart <input type="checkbox"/> Immunizations | Specific Information: | <input type="checkbox"/> Entire Record <input type="checkbox"/> Pertinent Info Only <input type="checkbox"/> History & Physical <input type="checkbox"/> Consult Report <input type="checkbox"/> Operative Report <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Lab <input type="checkbox"/> Imaging/Radiology <input type="checkbox"/> Cardiac Studies <input type="checkbox"/> Demographics <input type="checkbox"/> Nursing Notes <input type="checkbox"/> Medication Record |
|--|-----------------------|--|---|

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information. 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 the term Complete Chart for release of Protected Health Information means that only Records generated by this facility will be released. I have read the above and authorize the disclosure of the protected health information.

Signature of Patient/Parent/Legal Guardian _____ Date _____

NO DISKS, PLEASE!!!