

REQUEST FOR RELEASE OF MEDICAL RECORDS

This information for which I am authorizing disclosure will be used for the following purpose: (please check one)

- My personal use (there is a fee for personal use copies)
- sharing with other healthcare providers (No fee will be charged to the patient for information released to another physician for continued care; this can be demonstrated by having records sent directly to the treating physician or facility.)
- other please specify _____

I am requesting: all records lab reports radiology reports
 office notes consult reports billing records other (please specify)

Please check here if you are leaving our practice. Thank-you.

Name of patient(s): _____

Date (s) of Birth: _____

I authorize: _____
(Records coming from which dr.)

Address: _____ City-state & Zip: _____

To release information to: _____
(Records going to which dr, parent, etc...)

Address: _____ City, State & Zip: _____

FOR YOUR INFORMATION:

Original records legally belong to the treating physician.
 Patients have the right to view and/or have copies forwarded anywhere, the doctor's office has an obligation to forward records within a reasonable amount of time after receiving a signed release. **THIS WILL TAKE ANYWHERE FROM 2 TO 4 WEEKS.**
 Any person 18 years or older must sign his/her own release.
 I understand that I may revoke this authorization verbally or in writing at any time by filling out the appropriate form.
 I understand that treatment is not conditioned upon the execution of this authorization.
 I understand that any disclosure of information carries with it the potential for **redisclosure** and that the information then may not be protected by the federal confidentiality rules.
 I hereby release Pediatric Associates from any liability, which may result from the disclosure of any information requested.
 A copy of this authorization may be used with the same effectiveness as the original.
 This release will expire 1 year from date signed.
 I understand that I may be required to pay the cost of preparing and mailing copies except for uses and disclosures for the purpose of treatment, payment, and operations.

Processing fees & copying charges may apply for records released for any reason other than continuity of care

For personal use—(this fee is for each child's chart)-Request for medical information of fewer than 10 pages will be provided at no charge, pages 11-20 will be \$0.75 per page, then \$.50 a page for pages 21-? Actual postage or shipping costs may also be charged.

State of Colorado's Dept of Public Health & Environment recommended fee schedule (6 CCR 1011-1, chapter II §5.2.3.4) will apply to all other releases.

Please check here if you are leaving our practice. Thank you. Patient's Contact Number: _____

Patient/Parent/Guardian Name (PRINTED) _____ Date: _____

Patient/Parent/Guardian Signature: _____ Relationship to patient _____ Witnessed by: _____

_____ below for office use only _____

Processed by: _____ Date: _____ Pages: _____ Faxed: _____ Mailed: _____ Pick-up: _____

Signature for pick up: _____ Date: _____