

**Authorization/Release for Protected Health Information (PHI)**

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Patient Legal Name	Date of Birth	SSN
Address		Phone #
City	State	Zip Code

**Requesting Records From:**

**Records Being Sent To:**

Colorado Children's Medical Group, P.C.  
9397 Crown Crest Boulevard, Suite 211  
Parker, CO 80138  
Phone: (303) 369-6977  
Fax: (303) 369-1909

**Type Of Access Requested:**

<input type="checkbox"/> Copies of Records	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Consults	<input type="checkbox"/> Other – please specify
<input type="checkbox"/> Well Child Visits	<input type="checkbox"/> Labs	<input type="checkbox"/> Growth Charts	

**Reason to Release Information:** \_\_\_\_\_

**Expiration:** This authorization shall expire upon (circle one):

- Fulfillment of this request
- Date \_\_\_\_\_

- 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 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.

Signature of Patient/Parent/Legal Guardian \_\_\_\_\_

Today's Date: \_\_\_\_\_

\*\*Fee is \$14.00 for first 10 pages, \$.50 for pages 11 through 40, and \$.33 for each page thereafter, plus postage.