Authorization/Release for Protected Health Information (PHI)

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

Requesting Records From:

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

Records Being Sent To:

Type Of Access Requested:

__ Copies of Records __ Well Child Visits	__ Immunizations __ Labs	__ Consults __ Growth Charts	__ Other – please specify

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.