Southeast Denver Pediatrics, P.C.

2121 S. Oneida St., Suite 200, Denver, CO 80224
Ph: 303-757-6418, Fx: 303-757-2209

11960 Lioness Way, Suite 200, Parker, CO 80134
Ph: 303-471-5060, Fx: 303-471-5062

Authorization/Release for Protected Health Information (PHI)

Patient's Legal Name _____ Date of Birth _____

Address _____ Phone Number _____

City _____ State _____ Zip Code _____

I hereby authorize the following facility to disclose PHI of the patient listed above:

From:	To: (Please Complete for Records Transfer)
Southeast Denver Pediatrics, P.C.	Facility Name: _____
2121 S Oneida St, Suite 200	Address: _____
Denver, CO 80224	City/State/Zip: _____
Phone: 303-757-6418 Fax: 303-757-2209	Phone: _____ Fax: _____

Reason to release PHI: _____

Type of Access Requested (please circle those that apply):

Copies of Records	Entire Record	Labs	Progress Notes
Inspection of Records	Pertinent Info Only	Imaging/Radiology	Physician Orders
	E.R. Records	Cardiac Studies	Billing Records
	History & Physical	Demographics	Immunizations
	Consult Reports	Nursing Notes	Other (Please specify)
	Operative Reports	Medication Record	
	Rehabilitation Services		

This authorization shall expire upon (please check one):

- o Fulfillment of this request.
- o Date: _____

I acknowledge, and hereby consent to such, that the released information may contain alcohol/drug abuse, psychiatric, HIV/AIDS results 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)** For closed clinics, there will always be a fee for copying records. I understand that the term "Complete Chart" for release of PHI 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 _____

Fee Schedule

Fees for duplication of PHI 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 ten or fewer pages, $0.50 per page for pages 11-40, and $0.33 for every additional page thereafter**. Actual **postage or shipping costs are additional** and vary depending on the amount of records being sent. Copies of records are furnished by **Confidential Copiers, Inc.**