

Patient Information

Full Name _____ Date of Birth _____
Address _____ City _____ State & Zip _____
Day Phone # _____ Cell # _____

Release To

Name _____
Address _____ City _____ State & Zip _____
Phone # _____ Fax # _____

Release Form/Delivery

I would like my copies to be: Form: Paper Electronic (CD only)
Delivery: (Standard Mail by default) Pick-up Certified mail (Add'l \$5.30)

Purpose

Continuation of Care Personal Legal Insurance Other _____

Treatment Date(s)

Treatment dates from _____ to _____
 All treatment dates at Children's Hospital Colorado.

Information To Be Released

I would like copies of the entire visit for the treatment dates listed above.
 I would like copies of specific reports for the treatment dates listed above. (Check reports below.)
 Pertinent Info. (D/S, H&P, X-Ray, Operative, EKG, etc.) Discharge Summary History & Physical ED Reports
 Operative Consultation Laboratory Immunization Record
 Genetic Cardiac Studies Mental Health/Psych Radiology Reports
 Radiology Images Other _____

I understand that the information to be released may include a diagnosis or reference to the following condition(s): behavioral health services/psychiatric care; sickle cell anemia; genetic testing; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); or drug and/or alcohol abuse.

I Understand That

Without my express revocation, this authorization will automatically **expire** 180 days from the date signed below, unless I request an expiration date less than 180 days. I may choose to **revoke** this authorization at any time, except to the extent that action has already been taken to comply with it, by notifying Children's Hospital of Colorado in writing.
Information disclosed pursuant to the authorization may be subject to **redisclosure** by the recipient and is no longer protected by the HIPAA Privacy rule.
I will be provided a copy of this authorization upon fulfillment of the request.

Signature

My signature is required to validate this authorization. If I do not sign this authorization, Children's Hospital Colorado will still provide treatment and seek payment for services provided. According to Colorado State Statutes, Children's Hospital Colorado may charge for copies of medical records.

If patient is not able to sign, document reason: _____

Signature of Patient/Guardian/Personal Representative Relationship (if not patient) Date

Health Information Management/Children's Hospital Colorado/13123 E. 16th Avenue Box 150/Aurora, CO 80045 ROI @ Memorial
P: 720-777-4259 F: 720-777-7251 Radiology: P: 720-777-8625 F: 720-777-7132 P: 719-365-2491 F: 719-305-9721



Authorization to Disclose PHI

Patient Sticker