4m-e

Medical Record # ___________________________

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 of 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

P: 720-777-4259 F: 720-777-7251 Radiology: P: 720-777-8625 F: 720-777-7132

ROI @ Memorial

P: 719-365-2491 F: 719-305-9721

Authorization to Disclose PHI

HIM 6320-0003 (Rev. 08/12)

Patient Sticker