Pediatrics West, P.C.
Health care for the growing years

3555 Lutheran Pkwy, Suite 200, Wheat Ridge, CO 80033
Phone: (720) 284-3700 Fax: (303) 467-0525
13402 West Coal Mine Ave, Suite 200, Littleton, CO 80127
Phone: (303) 973-9300 Fax: (303) 973-930
Medical Records/Referrals
Fax: (303) 431-1038

Authorization/Release for Protected Health Information (PHI)

Patient's Legal Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

I hereby authorize the following facility to disclose Protected Health Information of the patient listed above.

Requested Delivery Method: ___ MyChart (Complete Set of Records/Never Expire) To **SIGN UP**, Call 720-777-4357

____ Pick Up ___ Fax Directly to New Provider (last 2 years only)

Facility and/or Dr's Name _____

From:		To:
Dr Name:		Dr Name:
Address		Address:
Phone #:		Phone #:
Fax #:		Fax #:

Reason for Transfer: _____

Type of Access Requested: Specific Date Range Requested:

Abbreviated Records:	Specific Information:		
__ Last Well Exam __ Growth Chart __ Immunizations		__ Entire Record __ Pertinent Info Only __ History & Physical __ Consult Report __ Operative Report Rehabilitation Services	__ Lab __ Imaging/Radiology __ Cardiac Studies __ Demographics __ Nursing Notes __ Medication Record

This authorization shall expire upon 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 the term Complete Chart for release of Protected Health Information mean that only Records generated by this facility will be released.
I have read the above and authorize the disclosure of the protected health information.
For closed clinics, there will always be a fee for copying of records.

_____

Signature of Patient/Parent/Legal Guardian Date