HIPAA AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

_____ Written Records _____ Verbal Patient Medical Information

Patient Name: (print) _____ **Date of Birth:** _____

Patient Name: (print) _____ **Date of Birth:** _____

Patient Name: (print) _____ **Date of Birth:** _____

Patient Name: (print) _____ **Date of Birth:** _____

Patient Name: (print) _____ **Date of Birth:** _____

Address: _____

_____ **Phone Number:** _____

Release To: _____

Address: _____

_____

Phone: _____

Fax: _____

Email: _____

Release From:

Kids First Pediatrics
96 Wadsworth Blvd 100
Lakewood CO 80226
(303) 239-8327
(303) 239-9946

I request and authorize the release of information to the organization, agency, or individual named above.
I understand that the information to be released may include the following condition(s).

1) Drug Abuse/Alcohol Abuse (Fed. Reg. 42 C.F.R., Part 2)
2) Psychological or psychiatric conditions
3) A test for the presence of antibodies (HIV)/virus which causes AIDS
4) An AIDS diagnosis and/or an AIDS related condition
5) Any third party source (hospital,specialist office,lab)

* * * According to Colorado Statutes (GCCR 1101-1,Rule XIV), there is a charge for copies of medical records. * * *
The charge is $18.00 for the first 10 pages, $.85/pages 11-39, and $.57/page for pages 40 and above.
*We **require** $18.00 up front to begin copying information.*
Medical records are sent as a courtesy at no charge directly to the patient's new doctor.

Information Requested (Please mark the box for all items you authorize to be released):

_____ **Chart Summary** (Problem list, Medications/Allergies list, Growth charts, Most recent physical, Major/Chronic illness, & Immunization record)

_____ Problem list _____ Immunization record Other describe: _____

_____ Medication List _____ Entire Chart

_____ Allergy List

From Date _____ To Date _____

Please note we do not release records from other facilities.

Purpose of release

_____ *Change of office* _____ *Specialist*

_____ *Insurance* _____ *Attorney / Guardian* *(Charges apply. Please fill out back side of this form)*

_____ *Move out of state* Other explain: _____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Practice Manager. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire ninety (90) days from the date of signature. I certify that this request has been made voluntarily. This authorization is subject to written revocation at any time, except to the extent that action has already been taken to comply with it. I release the above named from liability and claims of any nature pertaining to the disclosure of requested information contained in my medical records. I understand any disclosure of information contained in my medical records. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Personal representatives will not be provided access to records of a minor, 14yrs of age and older, for treatment if the minor was legally able to consent to treatment themselves unless the minor signs below allowing access to this information.

_____ **Patient or Legal Guardian/Executor (print)**
Copy of photo ID is required

_____ **Relationship to Patient**

_____ **Your Signature/Date**

_____ **Patient Signature/Date**

*** * * If patient is unable to sign, please document reason:** _____

*** * * INFORMATION REQUESTED WILL NOT BE PROVIDED IF ANY OF THE ABOVE ITEMS HAVE NOT BEEN COMPLETED. * * ***

KidsFirst Pediatrics, Prof. LLP

96 Wadsworth Blvd 100
Lakewood, CO 80226

T (303) 239-8327
F (303) 239-9946

HIPAA AUTHORIZATION FOR COST OF RELEASE OF PATIENT INFORMATION

Patient Name: (print)	**Date of Birth:**
Patient Name: (print)	**Date of Birth:**
Patient Name: (print)	**Date of Birth:**
Patient Name: (print)	**Date of Birth:**
Patient Name: (print)	**Date of Birth:**

* * * According to Colorado Statutes (GCCR 1101-1,Rule XIV), there is a charge for copies of medical records. * * *
The charge is $18.00 for the first 10 pages, $.85/pages 11-39, and $.57/page for pages 40 and above.
We require $18.00 up front to begin copying information.
Payment in full must be received before records will be given to individual/agency indicated on the Release Form.

Payment Type: *CASH* Credit Card: *MC* *VISA* *DISCOVER*

Name on Credit Card: _____ ***Cardholder Zipcode:*** _____

Credit Card Number: _____ ***Expiration Date:*** _____

PrePayment: ***$18.00*** per chart **Total Cost:** ***$*** _____

☐ Keep my credit card information on file to bill remaining amount and then discard credit card information. **Amount Remaining:** ***$***

When records are done, please:

☐ **Call me at** _____ so I may come pick-up records.

☐ **Mail to** *individual/agency indicated on the Release Form.*

By signing this form I agree to pay the charges as allocated above.

I certify that this request has been made voluntarily. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Practice Manager. I understand the revocation will not apply to information that has already been released in response to this authorization.

Personal representatives will not be provided access to records of a minor, 14yrs of age and older, for treatment if the minor was legally able to consent to treatment themselves unless the minor signs below allowing access to this information.

Signature of Patient or Legal Guardian/Executor **Relationship to Patient**

Print/Date **Patient Signature/Date**

*** * * INFORMATION REQUESTED WILL NOT BE PROVIDED IF ANY OF THE ABOVE ITEMS HAVE NOT BEEN COMPLETED. * * ***