Authorization for Disclosure of Protected Health Information

Patient Information

Patient Name _____ MR#_____
Last First MI (completed by TCH)

Birth date _____ Phone_____ SS# _____

Parent/Guardian/Requester Completing Form: _____

Release To

I authorize The Children's Hospital to Release Medical Record Information to:

Name _____

Address _____

City/State/Zip _____

Phone _____ Fax _____

Purpose:

For the following purpose:

- ☐ Continuation of Care
- ☐ Insurance
- ☐ Legal
- ☐ Personal Use
- ☐ Other

_____

Information to Release

Treatment Dates: From _____
To_____

- ☐ Pertinent Information (Discharge Summary, H&P, X-Ray, Lab, Surgery, EKG, etc)
- ☐ Emergency Room/Urgent Care ☐ Immunization Record
- ☐ Clinic Information/Notes ☐ Lab Reports
- ☐ Discharge Summary ☐ Imaging Results ☐ Copy of Images
- ☐ Complete Medical Record (except _____)
- ☐ Other _____

State/Federal Laws require specific authorization to release the following types of information. Please initial beside the types of information to be released:

____ HIV/AIDS Related ____ Genetic Testing ___ Drug/Alcohol abuse
____ Mental Health ____ Psychotherapy Notes ___ Sickle Cell Anemia

Fees:

The following fees are applicable and authorized by Colorado State Law:

$ 14.00 - 1 - 10 pages
$ .50/pg - 11- 40 pages
$ .33/pg - each add'l page

$1.50 per page for microfilm
X-Ray film - $14.00 per sheet
X-Ray CD - $14.00 per CD

Delivery Instructions:

- ☐ Call Requester for pick-up when records are ready.
- ☐ Mail records directly to person or organization specified.
- ☐ Other _____

I authorize _____ to pick up my Medical Records.

_____
Relationship to patient

Confirmation

Confirmation of Pick Up:

_____
Signature
Date _____
___CD __ Film
___ Checked out Existing Film

Patient/Authorized Representative Authorization

I understand that: (1) My signature on this form is strictly voluntary. (2) I may revoke this authorization at any time in writing, and if I do it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. (3) If the requester or receiver is not a health plan or health care provider, the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations. (4) If I do not sign this form, my health care, the payment for my health care or my ability to enroll for benefits will not be affected. (5) I may inspect or obtain a copy of the health information that I am being asked to disclose.

Expiration: Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified: _____.

☐ If this "box "is checked, the Facility will receive compensation for the use or disclosure of my information.

_____ _____ _____
Signature Relationship to patient Date

Health Information Mgmt / TCH / 13123 E. 16th Avenue Box 150 / Aurora, CO 80045
720-777-4259 / Fax 720-777-7251
Radiology 720-777-8625 / Fax 720-777-7132

The Children's Hospital
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