Denver Family Medicine
1960 Ogden Street, Suite 600 Denver, CO 80218
303-830-6666 (ph) 303-830-7099 (fax)

Authorization/Release for Protected Health Information (PHI)

(Please print)
Patient Name: _____ Date of Birth: ___/____/_____
Previous Name: _____ SS #: _____
Street Address: _____ City: _____
State: _____ Zip Code: _____ Phone #: (____)_____

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

TO / FROM (please circle)
Name: Denver Family Medicine
Address: 1960 Ogden St, Ste. 600
Denver, CO 80218
Phone: 303-830-6666
Fax: 303-830-7099

TO / FROM (please circle)
Name: _____
Address: _____
_____
Phone: (____)_____
Fax: (_____)_____

Reason(s) for this authorization (check all that apply):
□ Transfer of care □ Insurance □ Referral □ Personal

Release the following (check all that apply):
□ All information maintained by the named practice
□ All information within the following dates: _____ to _____
□ All information pertaining to: _____
□ Pathology Reports: _____ to _____
□ Laboratory Reports: _____ to _____
□ Radiology Reports: _____ to _____
□ Emergency Reports: _____ to _____
□ Discharge summary report: _____

If this Option is selected- it must be the only selected… *cannot be paired with records requests-This must reflect the same information as the TO/FROM recipient above*
□ My permission to discuss any medical condition with named person? YES NO (circle one)
If yes, whom? Name: _____ Relationship: _____

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 in writing except to the extent that it has been acted upon. 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 there may be a fee involved with the fulfillment of this request. (See fee schedule below.) I understand that the term Complete Chart for release of Protected Health Information means that only records generated by this facility will be released. I have read the above and authorize the disclosure of the protected health information.

Signature of Patient/Parent/Legal Guardian: _____
Date: _____ (Expires 1 year from signature date or upon revocation by patient/legal guardian.)

Fee Schedule

Fees for duplication of Protected Health Information shall follow the Regulations for Patient Medical Reproduction Fees 6 C.C.R. 1011-1, Chapter 2, Part 5.2.3.4. which states the patient shall pay for the reasonable cost of obtaining a copy of his/her patient record, not to exceed $14.00 for the first ten or fewer pages, $.50 per page for pages 11-40, and $.33 per page for every additional page. Actual postage or shipping costs and applicable sales tax, if any, may be charged.

***To ensure timely processing of medical records, please fill authorization out completely.**

Revised 04/2018