Southeast Denver Pediatrics, P.C.
Infants • Children • Adolescents

2121 S Oneida Street Suite 200
Denver, CO 80224
Phone: (303) 757-6418
Fax: (303)757-2209

11960 Lioness Way Suite 200
Parker, CO 80134
Phone: (303) 471-5060
Fax: (303) 471-5062

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
EACH STEP OF THIS FORM MUST BE COMPLETED

Information about the Patient (Please Print)

Patient Name: _____ Date of Birth: _____

Address: _____
Street City State Zip

Cell / Daytime Phone: _____ Patient Cell: _____

Authorization to release medical records FROM Southeast Denver Pediatrics TO:

I, _____ hereby authorize Southeast Denver Pediatrics, P.C. to release my protected health information to:

Name: _____

Address: _____
Street City State Zip

Phone: _____ Fax: _____

Authorization to release medical records TO Southeast Denver Pediatrics, P.C.

I, _____ hereby authorize Physician Name: _____

Address: _____
Street City State Zip

Phone: _____ Fax: _____

To release my protected health information to:
Southeast Denver Pediatrics P.C.

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As set forth:

- ☐ Entire Record (possible processing fee with this request)
- ☐ Only dates of treatment: _____
- ☐ Only medical data / information related to: _____
  - Specific conditions: _____
  - Specific service: _____
  - Specific medication: _____
  - Other: _____

Reason for Medical records request:

☐ Moving ☐ Insurance Reasons ☐ Changing Pediatricians ☐ Other: _____

Signature:

This authorization is valid for 90 days and may be revoked at any time in writing, except to the extent that action has been taken, prior to the expiration date. All revocations must be sent to the attention of the Privacy Officer / Medical Records for approval. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

_____ Date: _____
Patient's Signature or Parent / Guardian Signature

Sensitive Information

I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN PROTECTED HEALTH INFORMATION REGARDING DRUG AND ALCOHOL USE, PSYCHIATRIC TREATMENT, SEXUALLY TRANSMITTED INFECTIONS INCLUDING HIV OR OTHER SENSITIVE INFORMATION.

☐ I am agreeing to its release: _____ Date: _____
Signature of patient or parent / Guardian

☐ I do not want the following sensitive information released: _____

Fees

There will be a fee for medical records requested for personal use. CIOX, our copying service will contact you once your request has been processed to further discuss fee schedule