

Lowry Pediatrics

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below:

Patient Name _____ Birth Date _____ SSN _____

Address _____ Telephone _____

I AM REQUESTING RECORDS FROM: _____

*Name Of Office Is Required

Phone _____ Fax _____ Email _____

Address _____

Please Send Records To:

Lowry Pediatrics
8101 E. Lowry Blvd, Suite 260
Denver, CO 80230
Phone Number: 720-889-8222
Fax Number: 720-859-9777

Purpose of Request Is Required: _____

Please disclose the following information (please circle):

Entire Medical Record
Physicians Notes
Lab Results/ X-Ray Reports
Behavioral Health
Return to Work Authorization

Immunization Record
Daycare Forms
Sports Forms
Camp Forms

Other: _____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavior or mental health services or treatment for alcohol and drug abuse.

Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on _____ (Max. 6 months)

Signature of Patient or Guardian _____ Date _____

Relationship to Patient _____