MOUNTAIN PEDIATRICS

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Medical Records Release Form

I hereby authorize the use or disclosure of my child(ren)'s individually identifiable health information **from Mountain Pediatrics**.
I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. Please allow a minimum of 2 weeks for processing.

Patient(s):

Name_____ M ◯ F ◯ DOB_____/_____/_____

Name_____ M ◯ F ◯ DOB_____/_____/_____

Name_____ M ◯ F ◯ DOB_____/_____/_____

Name_____ M ◯ F ◯ DOB_____/_____/_____

Release Records To: Person or Clinic: _____

Address_____

City, State, Zip_____

Phone_____Fax_____

Reason for Transfer: _____

To Receive By E-mail: I understand that E-Mail or Electronic Transfer, once sent, is no longer secure.

◯ **Yes, Use My E-Mail Address: _____Initials: _____**

According to Colorado Statue (GCCR 1101-1, Rule XIV), there may be a charge for copies of medical records.
E-mail (Electronic transfer) and e-fax will be at no charge. Paper copies will be 0.25$ a page.

◯ I request the entire chart.

◯ Send only the abbreviated version: Last WCC, Vaccine History, Growth Charts, and Summary Sheets.

◯ I request only the information on the following treatment, condition, or the date(s):

_____

Do Not Allow This Protected Health Information to Be Included:

◯ Alcohol or Drug Use/Abuse Treatment ◯ Mental Health Treatment ◯ HIV/STD Status or Treatment

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. I understand that I have the right to refuse to sign this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law. I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law. I understand that this authorization is valid until it expires, unless revoked before that. I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office to the attention of the Privacy Officer. Absent such written revocation, this *Authorization Form for Release of Protected Health Information* will expire in 3-years from the date initiated below.

Print Name_____ Sign Name_____

Relationship to Patient(s)_____ Date_____

Address_____

City, State, Zip_____Phone_____