Advanced Pediatric Associates

Medical Records
3300 South Parker Road #404
Aurora, CO 80014

Patient Name: _____ **DOB:** _____

Authorization

Release From: _____ Release to: _____

_____ _____

_____ _____

_____ _____

Requested Information

☐ Entire Legal Medical Record
☐ Pertinent Legal Medical Records Only [including: Provider Progress Notes and Reports, Lab reports, Imaging Reports, Procedure Reports
☐ **Other records:**

☐ Telephone Consults	☐ Immunization Record	☐ Radiology reports	☐ Drug/Alcohol Testing
☐ Drug/Alcohol Testing	☐ Spirometry/EEG/ECHO tests	☐ HIV/AIDS Records	☐ Behavioral Health Records
☐ Billing Information	☐ Other: _____		

Dates of Services (between): _____ **and** _____

PLEASE NOTE: The information to be released may include a diagnosis or reference to the following condition(s): behavioral health services/psychiatric care, sickle cell anemia, genetic testing acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); drug and/or alcohol abuse, or sexually transmitted disease.
****Patient signature required below to release department specific records:**
Patient age 13 or older: Reproductive health including pregnancy and sexually transmitted disease, HIV/AIDS, or drug/alcohol treatment information.
Patient age 15 or older: Behavioral health or psychiatric care information.
Patient age 18 or older: Must sign release for all records.

Acknowledgement of Charges for Copying of Records

I acknowledge that in accordance with the Colorado Department of Public Health and Environment a fee may be charged for copies of medical records. The charge is $14.00 for the first ten or fewer pages, $0.88 pages 11-40, $0.75 pages 41+. Actual postage may also be charged if applicable. There is no charge for physician to physician record transfers.

My Rights

I **understand the following:** This authorization will automatically **expire** 1 year from the date signed below or the date the minor child becomes an adult under state law, unless I request an expiration date sooner than 1 year. I may choose to **revoke** this authorization at any time, except to the extent that action has already been taken to comply with it, by notifying Advanced Pediatric Associates in writing. Information disclosed pursuant to the authorization may be subject to **re-disclosure** by the recipient and is no longer protected by the HIPAA Privacy Rule. I

_____ _____ _____
Signature of Parent/Guardian *Relationship (parent, legal guardian)* *Date*

_____ _____
Printed Name *Signature of Patient (when required)*

Reason for Transfer

☐ Moved ☐ Insurance ☐ Location ☐ Other: _____ ☐ May we contact you about your transfer of records?

Phone: (303) 699-6200 Fax: (303) 766-6903