Lone Tree Pediatrics
10099 RidgeGate Pkwy # 360
TEL (303) 798-3247 FAX (303) 798-3248
info@lonetreepediatrics.com
lonetreepediatrics.com

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

To ensure timely processing of request, please print all information and fill out completely.

Patient Legal Name: _____ DOB:_____
LAST FIRST MIDDLE INITIAL mm/dd/yyyy

I hereby request/authorize the following facility to disclose Protected Health Information of the patient listed above.

FROM:
Lone Tree Pediatrics
10099 RidgeGate Pkwy.
Conifer Bldg., Ste. 360
Lone Tree, CO 80124
Phone: (303) 798-3247
FAX: (303) 798-3248

TO: Provider's Name _____
_____
Address:_____
_____
Phone: _____ FAX: _____

Reason to release Protected Health Information: *(Please check one.)*

☐ Transfer of Primary Care ☐ Referral to Specialist ☐ Insurance ☐ Personal

Release information to the following: *(Please check one.)*

☐ Parent/Guardian of child will pick up medical records. (Please provide the best number to reach you when records are available_____.)

☐ Mail records to Parent/Guardian of child. Please advise if there is a change of address.

☐ Mail or FAX records to another healthcare or provider or designated recipient as noted above.

Type of Information to be released: *(Please check one)*

☐ Copy of entire chart

☐ Summary of entire chart (Growth Chart, Problem list, Immunizations)

☐ Health Information related to the following treatment, condition and/or date(s): _____
_____

- I understand that the term "Chart" for release of Protected Health Information means that only records generated by this facility will be released.
- I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, sexual activity, HIV results and/or AIDS information.
- I understand this authorization may be revoked by me at any time except to the extent that action has been taken in reliance 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 details below).
- I have read the above and authorize the disclosure of the Protected Health Information. This release will expire 90 days from signature date.

_____ Date: _____
Signature of Patient/Parent/Legal Guardian

As a courtesy, there is no charge for records being sent to another healthcare provider. Copies of medical records for a parent, guardian or patient's personal use will require payment of the allowed fee. The medical record processing fee must be collected prior to record transfer from this office. ***Fees for duplication of Protected Health Information under HIPAA §164.502(g) are $14 for the first 10 or fewer pages; $.33 per page for every additional page; plus actual postage or shipping costs.***