Lone Tree Pediatrics

Lone Tree Office:
10099 RidgeGate Pkwy
Suite #290
Lone Tree, CO. 80124
Phone: (303)803-1005
FAX: (303) 798-3248

Littleton Office:
7720 South Broadway St.
Suite #540
Littleton, CO. 80122
Phone: (303) 779-3013
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E-mail: info@lonetreepediatrics.com
Website: lonetreepediatrics.com

AUTHORIZATION TO RELEASE 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

TO: Provider's Name ____________________________

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Address:______________________________________

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Phone: _______________ FAX: __________________

E-mail:_______________________________________

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

☐ Transfer of Primary Care ☐ Personal ☐ Other:__________

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): ____________________

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- 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 $18.53 for the first 10 or fewer pages; $.85 for pages 11-40, and $.57 for pages 41+; plus actual postage or shipping costs. Release of Medical Records FROM LTP 4/2019