Authorization to Release Protected Health Information (PHI) to Rose Pediatrics

Patient Legal Name: _____
Last First Middle (initial) Date of Birth

Address: _____

City: _____State:_____Zip Code:_____

Please fill out completely. Incomplete information can cause delay's in Release and/or Receipt of records.

I Hereby Authorize:

Name/Organization: _____

Address: _____ City/State: _____ Zip Code: _____

Phone: _____ Fax: _____

Reason(s) for this authorization: ☐ Transfer of Care to a New Provider due to: _____

☐ For Personal Records ☐ Other_____

Disclose Medical Records (PHI) of the patient listed above to:
Rose Pediatrics
4545 E. 9th Avenue #260, Denver, CO 80220
9137 Ridgeline Blvd. #130, Highlands Ranch, CO 80129

Please disclose the following medical record information (Check all that Apply)

☐ All my Health Records

☐ Other records related to: _____

☐ Specific Date Range From: _____ To: _____

Circle to Include or Exclude the following:

Include or Exclude: My health information related to drugs/alcohol abuse
Include or Exclude: My health information related to HIV/AIDS
Include or Exclude: My health information related to psychological/psychiatric conditions

My Rights:
I understand I do not have to sign this authorization form:

- in order to get healthcare benefits (treatment, payment, or enrollment)
- to take part in a research study
- to receive healthcare when the purpose is to create health information for a third party

I may revoke this authorization in writing, If I do, it will not affect any action already taken by the above-named practice based on this authorization.
I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke authorization are:

- Fill out a revocation form, form is available
- Or write a letter to the practice

Patient or legally authorized individual signature: _____

Printed Name: _____ Relationship to Patient: _____ Date: _____

Office Use Only: Date Processed: _____ Initials of OPMG Representative: _____

Authorization to Release Protected Health Information (PHI) From Rose Pediatrics

Patient Legal Name: _____
Last First Middle (initial) Date of Birth

Address: _____

City: _____State:_____Zip Code:_____

Please fill out completely. Incomplete information can cause delays in Release and/or Receipt of records.

I Hereby Authorize:

Rose Pediatrics
4545 E. 9th Avenue #260, Denver, CO 80220
9137 Ridgeline Blvd. #130, Highlands Ranch, CO 80129

Reason(s) for this authorization: ☐ Transfer of Care to a New Provider due to: _____

☐ For Personal Records ☐ Other_____

Disclose Medical Records (PHI) of the patient listed above to:

Name/Organization: _____

Address: _____ City/State: _____ Zip Code: _____

Phone: _____ Fax: _____

Please disclose the following medical record information (Check all that Apply)

☐ All my Health Records

☐ Other records related to: _____

☐ Specific Date Range From: _____ To: _____

Circle to Include or Exclude the following:

Include or Exclude: My health information related to drugs/alcohol abuse
Include or Exclude: My health information related to HIV/AIDS
Include or Exclude: My health information related to psychological/psychiatric conditions

My Rights:

I understand I do not have to sign this authorization form:

- in order to get healthcare benefits (treatment, payment, or enrollment)
- to take part in a research study
- to receive healthcare when the purpose is to create health information for a third party

I may revoke this authorization in writing, If I do, it will not affect any action already taken by the above-named practice based on this authorization.
I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke authorization are:

- Fill out a revocation form, form is available
- Or write a letter to the practice

Patient or legally authorized individual signature: _____

Printed Name: _____ Relationship to Patient: _____ Date: _____

All records are processed by HealthMark Group, a third party contracted service.
Please call (800) 659-4035 with Questions or to check the status of your medical record request.

Office Use Only: Date Processed: _____ Initials of OPMG Representative: _____

Authorization to Release Protected Health Information (PHI) From Rose Pediatrics

Patient Legal Name: _____
Last First Middle (initial) Date of Birth

Address: _____

City: _____State:_____Zip Code:_____

Please fill out completely. Incomplete information can cause delays in Release and/or Receipt of records.

I Hereby Authorize:

Rose Pediatrics
4545 E. 9th Avenue #260, Denver, CO 80220
9137 Ridgeline Blvd. #130, Highlands Ranch, CO 80129

Reason(s) for this authorization: ☐ Transfer of Care to a New Provider due to: _____

☐ For Personal Records ☐ Other_____

Disclose Medical Records (PHI) of the patient listed above to:

Name/Organization: _____

Address: _____ City/State: _____ Zip Code: _____

Phone: _____ Fax: _____

Please disclose the following medical record information (Check all that Apply)

☐ All my Health Records

☐ Other records related to: _____

☐ Specific Date Range From: _____ To: _____

Circle to Include or Exclude the following:

Include or Exclude: My health information related to drugs/alcohol abuse
Include or Exclude: My health information related to HIV/AIDS
Include or Exclude: My health information related to psychological/psychiatric conditions

My Rights:

I understand I do not have to sign this authorization form:

- in order to get healthcare benefits (treatment, payment, or enrollment)
- to take part in a research study
- to receive healthcare when the purpose is to create health information for a third party

I may revoke this authorization in writing, If I do, it will not affect any action already taken by the above-named practice based on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke authorization are:

- Fill out a revocation form, form is available
- Or write a letter to the practice

Patient or legally authorized individual signature: _____

Printed Name: _____ Relationship to Patient: _____ Date: _____

As a courtesy there is no charge for records being sent directly to another healthcare provider. Copies of medical records for a parent, guardian, patient Power of Attorney, or patient's personal use will require payment of the allowed fee. The medical records processing fee must be collected prior to record transfer from this office. Fees of duplication of PHI under the C.R.S. §25-1-801(5)(c)(I)(A) are $18.53 for the first 10 or fewer pages; $0.85 for ages 11-40, and $0.57 for pages 41+; plus actual postage or shipping costs.

Office Use Only: Date Processed: _____ Initials of OPMG Representative: _____