

<u>Authorization to Release Protected Health Information (PHI) to Rose Pediatrics - Highlands Ranch</u>

Patient Legal Last Name:		First	Middle (initial)	Date of Birth
Address:				
City:	State:	Zip Code:		
=				and/or Receipt of records.*
Hereby Authorize:	. ,	•	•	·
Name/Organization:				
Address:			City/State:	Zip Code:
Phone:	-C DTC	Fax:	1 - 1-	
Reason(s) for this authori: For Personal Records	zation:⊔ Transfer of Other	Care to a New Provider	due to:	
Disclose Medical Record	ds (PHI) of the pati	ent listed above to:		
Rose Pediatrics - Highlan	ds Ranch			
9137 Ridgeline Blvd Ste 1	30			
LITTLETON				
CO				
80129-2394 Form (202) 202 7144				
Fax: (303) 393-7144	Diagram diagram	Alon Collins do management		-11 4b -4 A b -2
		the following medical re	ecord information (Check	all that Apply)
 ☐ All my Health Records ☐ Other records related to 	and Images o:			
☐ Specific Date Range	From:	To:	<u> </u>	
☐ Specific Date Range	From:	To:To:	xclude the following:	
		Official to inicialate of E	Acidae the following.	
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Patient Legal Last		First	Middle (initial)	Date of Birth
Address:				
City:	State:	Zip Code:		
Please fi	ll out completely. Inc	omplete information can	cause delays in Release a	nd/or Receipt of records.
Hereby Authorize:				
Rose Pediatrics - Highla 9137 Ridgeline Blvd Ste LITTLETON CO				
80129-2394				
Fax: (303) 393 - 7144				
Reason(s) for this autho	orization: □ Transfer o	f Care to a New Provider o	due to:	
☐ For Personal Record				
Disclose Medical Reco	ords (PHI) of the pation	ent listed above to:		
Name/Organization:			N:t-:/Otata:	Zin Codo:
Address:			City/State:	Zip Code:
Phone:		Fax:		
	Please disclose	<u>the following medical re</u>	<u>cord information (Check all</u>	<u>l that Apply)</u>
☐ All my Health Record	ls			
Other records related ∴ …	d to:			
☐ Specific Date Range	From:	To:		
	10	Circle to Include or Ex		
Include or Exclude: My		ted to drugs/alcohol abuse	9	
		ted to hiv/AiD3 ted to psychological/psych	niatric conditions	
include of Exclude, My	nealth information rela	My Ric		
I understand I do not ha	ave to sign this authoris		into.	
		ment, payment, or enrollm	ent)	
• to take part in a re		nent, payment, or emount	ent)	
		is to create health informa	tion for a third party	
				ve-named practice based on this
authorization.		16 14	- :	and a suite and a
•		• •	n insurance. Two ways to rev	oke authorization are:
Or write a letter to	on form, form is availab the practice	oie		
Patient or legally author	rized individual signatu	re:		
Printed Name:		Relationship to Pati	ent:	Date:
P			Group, a third party contracte heck the status of your medic	
Office Hee Only Det	o Dronono d	1-10-	lo of ODMO Decrees	
Office Use Only: Dat	e Processed:	Initia	Is of OPMG Representative:	Revised 02.
				1/6/1960 02



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City:	State:	Zip Code:		
Please fill	out completely. I	ncomplete information car	n cause delays in Release a	and/or Receipt of records.
Hereby Authorize:				
Rose Pediatrics - Highlaı 9137 Ridgeline Blvd Ste LITTLETON				
CO				
80129-2394				
Fax: (303) 393-7144				
Reason(s) for this author □ For Personal Records			due to:	
		atient listed above to:		
			City/State:	Zip Code:
Phone:		Fax:		
	Please disclos	se the following medical re	ecord information (Check al	I that Apply)
☐ All my Health Records	3	-	•	
☐ Other records related	to:			
☐ Specific Date Range	From:	To:To:		
		Circle to Include or E	xclude the following:	
		elated to drugs/alcohol abus	e	
Include or Exclude: My h				
Include or Exclude: My h	ealth information re	elated to psychological/psyc		
		<u>My Ri</u>	<u>ghts:</u>	
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 to receive healthca 	re when the purpos	se is to create health informa	ation for a third party	
l may revoke this authori authorization.	zation in writing, If	I do, it will not affect any act	ion already taken by the abo	ve-named practice based on this
-			in insurance. Two ways to rev	oke authorization are:
		lable		
Or write a letter to t	the practice			
Patient or legally authoriz	zed individual signa	ature:		
Printed Name:		Relationship to Pat	tient:	Date:
guardian, patient Power must be collected prior to	of Attorney, or pation of the cord transfer from the cord transfer f	ent's personal use will requi om this office. Fees of duplic	re payment of the allowed fee	es of medical records for a parent, e. The medical records processing fee . §25-1-801(5)(c)(I)(A) are \$18.53 for the ing costs.
Office Head Only	Dunnan - di	1 10	als of ODMC Decrees and the	
Office Use Only: Date	FIUCESSEU.	Iniua	als of OPMG Representative:	

Revised 02.2021