LITTLETON PEDIATRIC MEDICAL CENTER

AUTHORIZATION/RELEASE OF PROTECTED HEALTH INFORMATION

*Standard Release (Patient Information sheet, immunization record, growth chart, last physical, last med check-if applicable) free of charge.

*Additional requests will have the following fee schedule:

*Base Fee $18.53 for first 10 pages.

*Pages 11-40 $0.85 per page

*Pages 41+ @$0.57 per page

I request that my / my child's medical records be copied and transferred from Littleton Pediatric Medical Center to:

Name _____

Address _____

City _____ State _____ Zip _____

Patient's name _____ Date of Birth _____

Person making request (print name) _____

Address _____

City _____ State _____ Zip _____

Phone # _____

Reason for leaving _____

Release these records

_____ Standard release _____ All records

Records from other providers outside of LPMC not included

I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it. I understand that this authorization will expire one year from the date signed unless noted. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected. I understand there will be a fee involved with this request. SEE FEE SCHEDULE ABOVE. I have read and understand the above and authorize the disclosure of the Protected Health Information. Fees will be collected and identity verified before release of records.

Littleton Pediatric Medical Center Fax 303-791-7756 Ken Caryl Fax 303-791-8790

Signature _____ Date _____

Patients 18 years of age and older must sign on their own behalf