Pediatric Associates Prof, LLC

947 S. 5th St., Montrose, Colorado 81401
242 Cottonwood St. Suite 101, Delta, Colorado 81416
Phone: 970-249-2421 **Fax Authorization to: 970-249-8897**
Fax Medical Records to: 970-249-8897

Authorization for Use and Disclosure of Protected Health Information:

Patient Name: _____ Date of Birth:_____
Address: _____
Phone Number:_____

Please **CHECK ONLY ONE BOX**: □ Mail Records □Fax Records □ Pick Records Up (bring valid ID)

Information Disclosed From:

_____
Name of Person or Organization

_____
Street Address

_____
City State Zip

_____
Phone Number Fax Number

Information Disclosed To:

_____
Name of Person or Organization

_____
Street Address

_____
City State Zip

_____
Phone Number Fax Number

Purpose or need for disclosure (check one): □ Further Medical Care □ Insurance Claim □Personal □ Moving □ Other_____

Type of Information to Be Disclosed: □Medical Records □Vaccination Records □Lab/Imaging Reports

2 year history will be requested unless specified: (date range) From :_____To_____

Your Rights with Respect to this Authorization

Drug and/or Alcohol , and/or Psychiatric, and/or HIV/AIDS Records Release:
I understand that the requested information may contain reference to or results of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information. I authorize the release of such confidential information to the indicated party, unless prohibited in my instructions above.

Time Limit & Right to Revoke Authorization
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at Pediatric Assoc. Prof., LLC, 947 S.5th St., Montrose, CO 81401. **Unless revoked, this authorization will expire one year from date of signature.**

Re-Disclosure
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 199 6. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure
I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can view or receive a copy of the protected health information to be used or disclosed. **I authorize Pediatric Assoc., Prof.,LLC. to use and disclose the protected health information as specified above.**

*****Copies of Records may be obtained with reasonable notice and payment of copying costs. FEES MAY APPLY. Please allow 7-10 business days to process your request. *****

Authorized Signature:_____ Date:_____
(If legal guardian, provide a copy of the court order establishing person's authority)

Person Signing Release: □ Parent of Minor □Legal Guardian □Self (if 18 years and older) □Other:_____

Internal Use Only

Front Desk :

Identity of Request Verified: □ Photo ID □ Matching Signature □ Other_____ Initials:_____

Medical Records:

Date Received:_____Date Faxed:_____ Date Completed:_____ Fee:_____ Initials:_____