Integrative Pediatric Health Care, LLC.

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Phone: 720.442.3615
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RECORDS RELEASE AUTHORIZATION

We attempt to complete all record release requests within 5-10 business days, in the event that there is a delay, we will not exceed 30 business days for the request. The records will include all immunizations, growth and development charts, and other records as identified below. If you are requesting copy of the full chart there is a charge for records. The charge is based lower than the Colorado State statute § 6 C.C.R. 1011-1, Chapter 2, Part 5.2.3.4. and in compliance with HIPAA § 165.524 (c, 4). The charges consist of $0.05 per sheet copied, $0.15 per envelope used, actual postage, and a charge of $0.30 per minute for the time to copy. Records are also available in an encrypted electronic media format at $0.37 per CD, $0.10 per envelope, actual postage for Media and passwords, and a charge of $0.30 per minute for the time to process. Payment must be made before records are picked up or mailed. If you want your entire medical record please indicate in the appropriate boxes below.
Thank you.

I authorize Integrative Pediatric Health Care, LLC to obtain or send protected health information:
(circle one)

Name of Dr. or Organization:____ ;
Address:____
____
Phone:___________________ Fax:____________________

Please send/obtain a copy of:

___ Basic Chart, limited to; Health Summary, last well visit, developmental information (i.e. DDST/ASQ), growth charts, and immunizations. (No fees)

___ The entire medical record, including but not limited to; immunization status, growth and developmental information, office notes, and consult notes. (Fees as above will be assessed)

Circle all below:

Include or Exclude My health information related to drug abuse
Include or Exclude My health information related to alcohol abuse
Include or Exclude My health information related to HIV/AIDS
Include or Exclude My health information related to psychiatric conditions/psychotherapy notes (Including notes regarding ADD/ADHD)

Child's name and date of birth:____ ____/____/______

____ ____/____/______

____ ____/____/______

Parents' Names: ___________________________ ____________________________

Phone Number: (______)___________________________

Reason for request:
____
____

Parent/+18 patient Signature __________________________________ Date:___/___/___

Name of signee; please print __________________________________

**This authorization will expire 90 days after the date identified above. You can cancel this authorization at any time, but you must do so in writing. If you cancel it, the authorized to use and disclose your protected health information may use the information collected prior to the date you revoked this authorization. Please send written revocation to the individual or department who you authorized to use your protected health information. Also, please be aware that once we disclosed this information per your instructions, the information is subject to re-disclosure and may no longer be protected.