Pediatric Partners OF THE SOUTHWEST

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PLEASE DO NOT FAX DOCUMENTS THAT EXCEED 10 PAGES IN LENGTH. PLEASE MAIL LARGE DOCUMENTS

Patient Name	Date of Birth	Parent/Guardian Email Address
Address	City, State, Zip	Telephone Number

I hereby authorize the facility listed below to disclose/release the Protected Health Information specified in this request to the organization, agency, patient, or person named.

Release by:	**Release to:**
_____ Name of Facility	_____ Name of Organization, Agency, Individual
_____ Address	_____ Address
_____ City, State, and Zip	_____ City, State, Zip
_____ Phone/Fax Numbers	_____ Phone/Fax numbers

Treatment Date(s): _____

Purpose: ☐

Further Medical Care ☐ Insurance
Personal Use Legal
Insurance ☐ Behavioral Health
Other: _____ ☐

Type of Disclosure Authorized & Delivery Instructions:
Records exceeding 10 pages must be MAILED ☐
EMAIL records to MedicalRecords@ppswdurango.com (for PPSW to receive records)
EMAIL records to your email provided above (for PPSW to release your records)
Mail records directly to address above
Call to pick-up records: _____
Fax records to: _____

Pertinent Protected Health Information Allowed to be Included:

☐

Discharge Summary	☐ Radiology ☐	Special Studies	School Records
History & Physical/Consult ☐	Outpatient Record ☐	Medication Records	Operative Report
Progress Notes ☐	Psych Health Records	Labs ☐	Physician Orders

Other (specify): _____

Last 3 Years

***Psychotherapy Notes are distinct and may not be included with the disclosure of any other protected health information. A Patient Authorization to Disclose Psychotherapy Notes may need to be completed.**

Authorization: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by submitting my request in writing to the designated Health Information Management / Medical Records department. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be as valid as the original.

I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copies of my medical record.

I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the designated Corporate Responsibility and Privacy Officer.

Expiration: Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 1 year from the date hereof, unless a different date specified here: _____

Acknowledgement: I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and Human Immunodeficiency Viruses (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS).

Signature: _____ Date: _____
Patient, Parent, or Legal Guardian
Minor's Signature is required for release of any records for treatment which the minor may authorize under Colorado Law.

Relationship (if other than patient): _____

Name of individual signing on behalf of patient: _____

Signature of Witness: _____Date: _____

Office Use Only: Attach copies of required identification *****RECORDS EXCEEDING 10 PAGES MUST BE MAILED*****

Number of pages released: _____ Completion date: _____ Delivery Method: _____

Name of individual who received request: _____ Date received: _____