Rocky Vista Health Center

Medical Records
8401 S Chambers Rd, Suite H101
Parker, CO 80134

Patient Name: _____ **DOB:** _____

Authorization

Release From: _____ Release to: _____

_____ _____

_____ _____

_____ _____

Requested Information

☐ Entire Legal Medical Record
☐ Pertinent Legal Medical Records Only [including: Provider Progress Notes and Reports, Lab reports, Imaging Reports, Procedure Reports
☐ **Other records:**

☐ Telephone Consults	☐ Immunization Record	☐ Radiology reports	☐ Drug/Alcohol Testing
☐ Drug/Alcohol Testing	☐ Spirometry/EEG/ECHO tests	☐ HIV/AIDS Records	☐ Behavioral Health Records
☐ Billing Information	☐ Other: _____		

Dates of Services (between): _____ **and** _____

PLEASE NOTE: The information to be released may include a diagnosis or reference to the following condition(s): behavioral health services/psychiatric care, sickle cell anemia, genetic testing acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); drug and/or alcohol abuse, or sexually transmitted disease.

Acknowledgement of Charges for Copying of Records

I acknowledge that in accordance with the Colorado Department of Public Health and Environment a fee may be charged for copies of medical records. The charge is $18.53 for the first 10 pages, pages 11-40, $0.85each, and each additional page $0.57 each. Actual postage may also be charged if applicable. There is no charge for physician to physician record transfers.

My Rights

I **understand the following:** This authorization will automatically **expire** 1 year from the date signed below or the date the minor child becomes an adult under state law, unless I request an expiration date sooner than 1 year. I may choose to **revoke** this authorization at any time, except to the extent that action has already been taken to comply with it, by notifying Advanced Pediatric Associates in writing. Information disclosed pursuant to the authorization may be subject to **re-disclosure** by the recipient and is no longer protected by the HIPAA Privacy Rule. I

_____ _____ _____
Printed Name Signature Date

Reason for Transfer

Moved ☐ Insurance ☐ Location ☐ Other: _____ ☐ May we contact you about your transfer of records?

Phone: (720) 875-2880 Fax: (720) 875-2877