LITTLETON INTERNAL MEDICINE
ASSOCIATES

Specialists in Prevention Diagnosis and Treatment of Adult Illness

AUTHORIZATION/RELEASE FOR PROTECTED HEALTH INFORMATION (PHI)

Patient Legal Name: _____ Date of Birth: _____

Social Security Number: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

I hereby authorize the following facility to disclose Protected Health Information of the Patient listed above.

FROM: Facility/Doctor Name
Name/Title: _____
Address: _____
Phone: _____
Fax Number: _____

(MUST BE COMPLETE ADDRESS) TO:
Name/Title: _____
Address: _____
Phone Number: _____
Fax Number: _____

Reason to Release Protected Health Information:

_____

Type of Access Requested:

Specific Date Range Requested:

☐ Copies of Records	☐ Entire Record	☐ Lab	☐ Progress Notes
	☐ Pertinent Information ONLY	☐ Imagine/Radiology	☐ Physicians Orders
	☐ ER Records	☐ Cardiac Studies	☐ Billing Records
	☐ History & Physical	☐ Demographics	☐ Immunizations
	☐ Consult Report	☐ Nursing Notes	☐ Other
	☐ Operative Report	☐ Medication Record	
	☐ Rehabilitation Services		

Expiration: This authorization share expire (check one) *If notified out auth will expire one year from date signed:*

☐ Fulfillment of this Request ☐ Date: _____

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, STD, HIV results or AIDS information.

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.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

The facility will not condition treatment, payment, enrollment, or eligibility for benefits upon authorization unless specified use applies to specific exceptions.

I understand that there may be a fee involved with the fulfillment of this request. See fee schedule below.

I understand that the term Complete Chart for release of Protected Health Information mean that only records generated by this facility will be released.

I have read the above and authorize the disclosure of the protected health information.

For closed clinics, there will always be a fee for copying of records.

Signature of Patient/Parent/Legal Guardian: _____ Date: _____

Printed Name: _____ Relation to Patient: _____

PATIENT FEE SCHEDULE

Fees for duplication of Protected Health Information being released directly to the patient will be charged the following, $.39 per *page for pages 1-40 and $.36 per page for pages 41+. Actual postage or shipping costs and applicable sales tax, if any* may be charged. Records may be requested and released by attorney will follow Colorado State Statute rates

*To ensure timely processing of medical records, please fill authorization out completely.

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