Rocky Mountain Pediatric Pulmonology
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Helping your child…with inspiration!

Authorization to Release Healthcare Information

Release Records From:	**Patient's Name/Info:**	**Release Records To:**
Facility:_____	Name:_____	Facility:_____
Address:_____	DOB:_____	Address:_____
Ph: _____	Ph:_____	Ph:_____
Fax:_____	Fax:_____	Fax: _____

1. This request and authorization applies to:
   - ☐ All records
   - ☐ Laboratory/Pathology Reports
   - ☐ Radiology Records
   - ☐ Discharge Summaries
   - ☐ Prescription Records
   - ☐ Other (please describe)
     _____
     _____

***We can only copy our medical records: we can NOT forward copies of our records that we received from any other physician. You will need to obtain those records from them directly.**
*** This authorization to release your medical information shall expire one year from the date of the original signature**
***PLEASE NOTE: It could take up to 2 weeks for to copy and send the records (depending on the workload). If you need them sooner please make note at the top of the page, although we cannot guarantee they will be ready.**

2. The information may be used/disclosed for the following purposes:
   - ☐ At my request
   - ☐ For my healthcare
   - ☐ For payment/insurance
   - ☐ For employment purposes
   - ☐ Other: _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient (or patients representative) Date

_____
Printed name of representative