Authorization to Release Protected Health Information (PHI) From Lone Tree Pediatrics

Patient Legal Name: ____
Last First Middle (initial) Date of Birth

Address: ____

City: ____________________________State:_________________________________Zip Code:______________________

Please fill out completely. Incomplete information can cause delays in Release and/or Receipt of records.

I Hereby Authorize:

Lone Tree Pediatrics
10099 RidgeGate Pkwy, Ste 290
Lone Tree, CO, 80124

Lone Tree Pediatrics
7720 S. Broadway, Ste 540
Littleton, CO 80122

Reason(s) for this authorization: ☐ Transfer of Care to a New Provider due to: ____

☐ For Personal Records ☐ Other____

Disclose Medical Records (PHI) of the patient listed above to:

Name/Organization: ____

Address: ____ City/State: ________________________ Zip Code: ___________

Phone: ___________________________________ Fax: ____

Please disclose the following medical record information (Check all that Apply)

☐ All my Health Records

☐ Other records related to: ____

☐ Specific Date Range From: _____________________ To: _______________________

Circle to Include or Exclude the following:

Include or Exclude: My health information related to drugs/alcohol abuse
Include or Exclude: My health information related to HIV/AIDS
Include or Exclude: My health information related to psychological/psychiatric conditions

My Rights:
I understand I do not have to sign this authorization form:

- in order to get healthcare benefits (treatment, payment, or enrollment)
- to take part in a research study
- to receive healthcare when the purpose is to create health information for a third party

I may revoke this authorization in writing, If I do, it will not affect any action already taken by the above-named practice based on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke authorization are:

- Fill out a revocation form, form is available
- Or write a letter to the practice

Patient or legally authorized individual signature: ____

Printed Name: ______________________ Relationship to Patient: ____________________ Date: ____________

All records are processed by HealthMark Group, a third party contracted service.
Please call (800) 659-4035 with Questions or to check the status of your medical record request.

Office Use Only: Date Processed: _______________ Initials of OPMG Representative: ________________________

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