Authorization to Release Protected Health Information (PHI) to 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 delay's in Release and/or Receipt of records.

I Hereby Authorize:

Name/Organization: _____

Address: _____ City/State: _____ Zip Code: _____

Phone: _____ Fax: _____

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:
Lone Tree Pediatrics
Fax: (303) 798-3248

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: _____

Office Use Only: Date Processed: _____ Initials of OPMG Representative: _____