



LITTLETON PEDIATRIC MEDICAL CENTER

AUTHORIZATION/RELEASE of PROTECTED HEALTH INFORMATION
Records copied by CIOX with the following fee schedule:

FEE SCHEDULE

Fees for duplication (copy) of Protected Health Information is as follows:
Base fee \$14.00 for first ten pages; pages 11 - 40 @\$0.50 per page (max qty 30); pages 41+ @ \$0.33 per page.

I request that my medical records/my children's medical records be copied and transferred from Littleton Pediatric Medical Center to:

Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Child's Name Date of Birth:

Person making request _____

Phone # _____

Print name: _____

Signature: _____

Patients 18 years of age and older must sign on their own behalf.

Date: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Reason for leaving: _____

Release these records:

1. Only records generated by this facility (not including records received from other sources): _____
2. Only some portion of records maintained at facility: _____
3. All medical records at this facility: _____

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. I understand that this authorization will expire one year from the date signed unless noted. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected. I understand there will be a fee involved with this request. *SEE FEE SCHEDULE ABOVE.* I have read and understand the above and authorize the disclosure of the Protected Health Information.

(Littleton Pediatric Medical Center - Fax: 303-791-7756)

Signature of Patient/Parent/Legal Guardian

Date