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