Request For Outside Medical Records

Patient's Complete Name: Last: _____ First: _____ Middle: _____

Date of Birth _____/_____/_____ Last 4 digits of Social Security Number: xxx – xx - _____

INFORMATION TO BE RELEASED FROM:	INFORMATION TO BE RELEASED TO:
_____ Organization	International Center for Colorectal Care **Children's Hospital Colorado (CHCO)** Organization / Person
_____ Street Address City, State, Zip	**13123 E. 16th Ave.** B323 **Aurora, CO 80045** Street Address Box City, State, Zip
_____ Phone Fax	720-777-9880 720-777-7891 Phone Fax

INFORMATION TO BE RELEASED

Format for records (please check ONLY one box): ☐ **FAX** ☒ **PAPER** ☒ **CD** ☐ **OTHER**

Dates of service for records requested: Beginning _____ **Thru** _____

☒ Pertinent Information (Discharge Summary, H&P, X-Ray, Lab, Operative, Consults)	☐ Complete Medical Record	☐ Immunization Records	☒ Operative Reports
	☒ Clinical Information/Notes	☒ Lab Report	☐ Emergency Room/Urgent Care
	☒ Discharge Summary	☒ Pathology Report	☒ Imaging Results
	☒ Other (please specify) all images on disc		

PURPOSE OF RELEASE

☐ Continuation of Care ☐ Other_____

AUTHORIZATION FOR GENERAL RELEASE OF INFORMATION

I understand that:
(1) My signature on this form is strictly voluntary. (2) I may revoke this authorization at any time in writing, and if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. (3) If the requester or receiver is not a health plan or healthcare provider, the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations. (4) If I do not sign this form, my healthcare, the payment for my healthcare or my ability to enroll for benefits will not be affected. (5) I may inspect or obtain a copy of the health information that I am being asked to disclose. **Expiration**: Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified _____.

Sensitive Records may require specific patient authorization. Please check the applicable box below to request the following records:

☐ **Mental Health Treatment** ☐ **Sexually Transmitted Diseases** ☐ **AIDS/HIV Related** ☐ **Alcohol/Drug Abuse Treatment**
☐ **Psychotherapy Notes** ☐ **Sickle Cell Anemia** ☐ **Genetic Testing**

This form must be filled out completely in order to obtain medical records

SIGNATURE OF PATIENT / LEGAL REPRESENTATIVE

_____
Signature of Patient or Legal Representative Date (month/day/year)

_____
Relationship to patient, if not signed by patient

Patient Sticker