AURORA DENVER CARDIOLOGY ASSOCIATES

Authorization to Release Protected Health Information

Patient Information

Full Name _____ Medical Record # _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Date of Birth _____

Release From

I hereby authorize:

- ☐ ADCA - Aurora Office, 1444 South Potomac, Ste 300, Aurora, CO 80012 PH (303) 750-0822 FAX (303) 750-1298
- ☐ ADCA - Parker Office, 9397 Crown Crest Blvd., Ste 400 Parker, CO 80138 PH (303) 840-1135 FAX (303) 840-1279
- ☐ ADCA - PSL Office, 1601 E. 19th Ave., Ste 5000 Denver, CO 80218 PH 303-839-7100 FAX (303) 839-7249
- ☐ ADCA - Sky Ridge Office, 10103 RidgeGate Pkwy., Suite 103 Lone Tree, CO 80124 PH (303) 645-0090 FAX (303) 645-0092
- ☐ Other: _____

Name / Title Organization _____

Address _____

City / State / Zip _____ Phone _____ Fax _____

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Purpose & PHI Disclosed

☐ Continuation of Care ☐ Insurance ☐ Legal ☐ Patient Request ☐ Other _____

For Treatment Date(s) _____

☐ Progress Notes ☐ H&P ☐ Consultation Notes ☐ Treatment Plans ☐ Operative Reports

☐ Nursing Notes ☐ EKG ☐ Laboratory Results ☐ Pathology Reports ☐ Radiology Reports

☐ Cath Reports ☐ All ☐ Other _____

Fees

Pages	1 - 10	11 - 40	41+
Patient	$14.00	.50 each	.33 each
Others	$16.50	.75 each	.50 each

According to Colorado State Statute 6.C.C.R 1011, Ch 2 Part 5.2.3.4 the following fees may be charged for copies of medical records. Records will be provided to other health care providers at no charge.

$45 processing fee for requests other than direct patient requests for treatment, payment, and health care operations.

Authorization

Prior to the release of information, the following must be provided:
Copy of photo ID (Valid Drivers License/State ID and/or Passport)
and a physical street address for records that are to be mailed (no P.O. Boxes)

I may revoke this authorization at any time in writing, but if I do, it will have no effect on the actions taken prior to receiving the revocation. I understand that information disclosed pursuant to the authorization may be subject to redisclosure by the recipient and is no longer protected by the HIPAA privacy rule.
Without my express revocation, this consent will automatically expire 180 days from the date signed below, unless I request an expiration date less than 180 days.

Signature

My signature is required to validate this authorization. If I do not sign this form, my health care, the payment for my health care or my ability to enroll for benefits will not be affected.

_____

Patient or Authorized Representative Signature Date Relationship