Office Use Only:
Date Faxed: _____

Authorization/Release for Protected Health Information (PHI) Requested From:

Previous Medical Office* Office Phone#* Office Fax#*

Patient Legal Name* Date of Birth* Alias/Former Name

Patient Address* Patient Phone#*

City* State* Zip Code*

I hereby authorize my Protected Health Information to be released to:

CLINIX HEALTH SERVICES OF COLORADO
7030 S Yosemite St
Centennial, CO 80112
Phone: (303) 721-9984 Fax 303-267-7304 ***PLEASE DO NOT FAX IF OVER 25 PAGES***
www.clinixusa.com

Clinix Prefers Records electronically either CD

Please do not send entire chart unless specified

Check Appropriate Age Group*

☐	**18-39 years**		
	✓Last two office notes	✓Immunization Records	✓Past one year of labs/Paps
	✓Medication Lists	Special Items:	
☐	**40-64 years**		
	✓Colonoscopy and Pathology	✓Immunization Records	✓Past one year of labs/Paps
	✓Medication Lists	✓ Past One year of office notes	✓Imaging Results
	✓Diabetic Eye exams	✓Cardiac Testing	✓Specialist Reports
	✓**Females:** All breast Imaging	✓DEXA	Special Items:
☐	**Other Documents:**		
	***Reason to Release PHI:**		

***Signature of Patient/Parent/Legal Guardian_____ Date_____**

Name of person authorized to request release of information and relationship to patient, if not the patient (supporting documentation required i.e. medical power of attorney) _____

Expiration: This authorization shall expire upon : ☐ Fulfillment of this request

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.
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.
The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
I understand that I may refuse to sign this authorization and that you may not condition treatment or payment on me providing this authorization.
I understand that there may be a fee involved with the fulfillment of this request. **See fee schedule below.**
I understand that the term Complete Chart for release of Protected Health Information means that **only records generated by this facility will be released.**
I have read the above and authorize the disclosure of the protected health information.

Fee Schedule

Fees for duplication of Protected Health Information shall follow the regulations for Patient Medical Reproduction Fees 6 C.C.R. 1011-1, Chapter 2, Part 5.2.3.4. which states the patient shall pay for the reasonable cost of obtaining a copy of his/her patient record, not to exceed $14.00 for the first ten or fewer pages, $.50 per page for pages 11-40, and $.33 per page for every additional page. Actual postage or shipping costs and applicable sales tax, if any may be charged.