Office Use Only:
Date Faxed:



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

Previous Medical Provider* Patient Legal Name*		Phone#*	Fax#* Alias/Former Name	
		Date of Birth*		
Patien	t Address*	Patient Phone#*		
City* I herel	by authorize my Protected Health Info	State*	Zip Code*	
	, ,	CLINIX HEALTH SERVICES OF COLORADO 7030 S Yosemite St Centennial, CO 80112 -9984 Fax 303-267-7304 PLEASE DO NOT FAX IF www.clinixusa.com linix Prefers Records electronically either C		
Chocl	Pl k Appropriate Age Group*	ease do not send entire chart unless specifi	ed	
	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:			

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.

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.