7030 S Yosemite
Centennial CO 80112
Phone: (303) 721-9984 Fax: (303) 267-7304
www.clinixusa.com

Authorization/Release for Protected Health Information (PHI)

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

Address | Phone#

City | State | Zip Code

I hereby authorize Clinix Center for Health to disclose Protected Health Information of the patient listed above to:

Name/Title_____

Address _____

_____

Phone # _____

Fax# _____

I would like my records on _____ CD _____ thumb drive _____ **email:_____

Reason to Release Protected Health Information_____

Type of Access Requested: If related to an auto accident/work comp accident, please provide date of accident:_____

○ Copies of Records	○ ER Records ○ History & Physical ○ Consult Report ○ Operative Report ○ Rehabilitation Services	○ Lab ○ Imaging/Radiology ○ Cardiac Studies ○ Medication Record	○ Physicians Orders ○ Immunizations ○ Other

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.

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) _____

*** To ensure timely processing of medical records, please fill authorization out completely.**

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. Storage retrieval fees, actual postage or shipping costs and applicable sales tax, if any may be charged.