

**Authorization/Release for Protected Health Information (PHI)
Records Furnished by CCI**

Patient Legal Name _____ Date of Birth _____ SSN _____

Address _____ Phone# _____

City _____ State _____ Zip Code _____

I hereby authorize Peak Pediatrics to disclose Protected Health Information of the patient listed above to:

Name/Title _____

Address _____

Phone # _____

Reason for Release of Protected Health Information _____

Type of Access Requested:

<input type="checkbox"/> Copies of Records	<input type="checkbox"/> Entire Record	<input type="checkbox"/> Lab	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Inspection of the record	<input type="checkbox"/> ER Records	<input type="checkbox"/> Imaging/Radiology	<input type="checkbox"/> Physicians Orders
	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Cardiac Studies	<input type="checkbox"/> Billing Records
	<input type="checkbox"/> Consult Report	<input type="checkbox"/> Demographics	<input type="checkbox"/> Immunizations
	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Nursing Notes	<input type="checkbox"/> Other
	<input type="checkbox"/> Rehabilitation Services	<input type="checkbox"/> Medication Record	

Expiration: This authorization shall expire upon (check one):
 Fulfillment of this request
 Date _____

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 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 mean that **only records generated by this facility will be released.**
 I have read the above and authorize the disclosure of the protected health information.

Date _____

Signature of Patient/Parent/LegalGuardian _____

Fee Schedule: Please check mark below which option

- Option 1 () Free – Immunization and Growth Charts Only
- Option 2 () \$20.00 - For records generated from this facility and going to patient, 100 pages or less.
- Option 3 () \$25.00- For records generated from this facility entire medical records, 100- 200 pages.
- Option 4 () \$40.00- Family rate for three or more members of one family. Last 2 years per chart. Less than 100 pages per chart.

*** To ensure timely processing of medical records, please fill authorization out completely and attach your check for the appropriate amount or pay by credit card using the form on the back. Make all Checks payable to CCI.**