

Highlands Integrative Pediatrics, PC

2650 18<sup>th</sup> Street, Suite 100

Denver, CO 80211

P: 720.583.4470 F: 888.463.5887

**Medical Records Release Authorization (To HIP)**

I authorize \_\_\_\_\_ to release protected health information to Highlands Integrative Pediatrics.

Previous Physician's office address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Please send:

Basic Chart, limited to: immunization record, growth and development charts, last well visit notes, and problem list

Entire Chart, including but not limited to: immunization record, growth and development charts, all office and consultation notes.

\*\*\* The previous office may charge fees for copying medical records, so please contact them with any questions/concerns.

Please choose one of the following options:

I will **PICK-UP** records when they are ready.

Please **MAIL** medical records to HIP at the above address.

Please **FAX** medical records to HIP: 888-463-5887 (20 pages maximum. If exceeds 20 pages, please mail).

Please **MAIL** medical records to my home address below.

Please **EMAIL** medical records to HIP at *secure@hipediatrics.net*

Child's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

PATIENT OR PARENT/GUARDIAN SIGNATURE:

\_\_\_\_\_  
(If over 18 years of age, patient must sign) DATE: \_\_\_\_\_

Name of Signee (please print): \_\_\_\_\_

Address: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

\*\* PLEASE NOTE: This authorization will expire 90 days after the date identified above. In the event that you need to cancel this authorization, the cancelation must be received in writing. If the records have already been sent to the organization listed on this request, a separate written revocation must be sent to those persons.

**NOTE: When this form is completed, please mail or fax it to your previous doctor in order to have the records copied and sent to our office. THANKS!**