Request to Copy Health Information

Ponderosa Family Physicians
14991 E. Hampden Ave. #210
Aurora, CO 80014
303-690-4891

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have a right to request to copy health information that pertains to you. Unless otherwise notified, your records will be copied within two weeks of the date of this request. If we cannot grant your request to copy health information, we will notify you to explain why your request will not be granted.

I hereby request to copy health information for:

_____

Print Patient Name DOB SSN

I would like the following information copied:

- ○ (Free) Last three years of records generated from this facility going to another doctor/facility.
- ○ ($15) Last three years of records generated from this facility going to the patient/guardian/personal rep.
- ○ ($20) Complete set of records going to another doctor/facility or patient/guardian/personal rep.
- ○ ($40) Family rate for three or more members of one family. Last three years of records going to the patient/guardian/personal rep.
- ○ ($60) Family rate for complete set of records going to another doctor/facility or the patient/guardian/personal rep.
- ○ (?) The following portion of the record concerning: _____

_____

(Specify dates of treatment, disease, accident, or other portion of records you are interested in)

****Postage and handling will be added to the prices above.****
You will be invoiced by our copy service for the appropriate charges.

Release information to:

_____
_____
_____
_____

Patient/Guardian Address:

_____
_____
_____
_____

I hereby authorize Ponderosa Family Physicians to release the specified information to the individual/facility named on this request. I understand that by signing this authorization, I give permission for records concerning HIV/AIDS, psychological reports and/or alcohol/drug abuse to be released.
Any patient 18 years of age or older must sign for their own records.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- ○ parent or guardian of patient
- ○ beneficiary or personal representative