DENVER INDIAN HEALTH AND FAMILY SERVICES, INC.

2880 W HOLDEN PL, DENVER, CO 80204 PH: (303) 953-6600 FAX: (303) 781-4333 WWW.DIHFS.INFO

Records Request

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFROMATION TO DENVER INDIAN HEALTH & FAMILY SERVICES. Please disclose the requested record of the individual named below for continuation of treatment.

Patient Name: _____

Date of Birth: _____

Last 4 of SSN: _____

Information Requested From/To:

Provider/ Organization:					
Street Address:					
City:		**State:**		**Zip:**	
Fax:					
Phone:					

The type of information to be disclosed:

☐ Most recent		**(years) of records**	**Most Recent:**
			☐ Psychological Test Reports
☐ Immunizations			☐ Diagnosis and Treatment
☐ Growth Charts			☐ Physical Exams
☐ Operative Reports			☐ Medication List
	YEAR		☐ Mammogram and PAP
☐ Laboratory Results		to present	☐ Colonoscopy
☐ Discharge Summaries		to present	☐ EKG
☐ Specialty Consults		to present	☐ Tribal Enrollment
☐ X-Ray, CT, MRI and/or PET scans reports		to present	☐ Birth Certificates
☐ Other			

Note: I understand my records are confidential and cannot be disclosed without my written consent. I also understand that I may revoke this consent at any time and that in any event this consent expires automatically in _____ days from signed below.

Note: I understand that the medical information released by this authorization my include information concerning treatment of physical or mental illness, past medical history alcohol/drug abuse, HIV/Aids, or other sensitive information.

Patient / Guardian Signature: _____ Date: _____

Patient Representative Signature: _____ Date: _____

***If over 50 pages please mail records to:**

Denver Indian Health & Family Services
2880 W HOLDEN PL
Denver CO, 80204
Phone 303-953-6600
Fax 303-781-4333