Immunizations Medical Records Request Form **Date of Request: _____/_____/_____**

Patient's Name: _____ Date of Birth: ____/____/____

Name of Requester if different than patient: _____

Relationship to client if different than patient: _____

Requested via (e.g., in-person, telephone, email, fax – provide contact information):
_____

Complete the following information for each patient medical records requested:

Patient's Name: _____ Date of Birth: ____/____/____

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Patient's Name: _____ Date of Birth: ____/____/____

Please indicate the number of copies/originals: Copies: _____ Originals: _____

- Requests will be processed within 30 days of the date of the request.
- Identity (e.g., photo ID) must be verified in order to release records.
- **COSTS:** You will be charged a fee for photocopying, which is (waived for requests under 5 pages) a flat rate of $18.53 for 5 to 10 pages; $0.85 per page 11-40; and $0.57 for pages 41 and up. Payment must be made at the time of delivery of the requested material; or payment must be made prior to the mailing of copies of records.

What records are you requesting?

☐ Entire records maintained by EPCPH Immunization Program.

How would you like to receive your records? Photo ID is required to release records (see EPCPH HIPAA Identity Verification Prior to Disclosure of Protected Health Information policy)

☐ Receive In-person copies: Pick up at the Citizens Service Center, El Paso County Public Health (1675 Garden of the Gods Road, Colorado Springs, CO 80907).
☐ Fax to: _____ at Fax Number: _____
☐ Receive copies via mail:
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
☐ Receive copies via email:
Name: _____ Email Address: _____

I understand that EPCPH will still provide services to me even if I do not sign this approval form.

I understand that the persons or organizations listed above might share my health information, that EPCPH is not responsible if that should happen, and that Federal Privacy Laws or Regulations will no longer protect this information once EPCPH has fulfilled my request.

I understand that I can change my mind and cancel my approval at any time. I understand this request to cancel my approval must be in writing and sent to address below. I understand that the withdrawal of my approval will not apply to information that has already been released in response to this authorization.

Privacy Officer
El Paso County Public Health
1675 W. Garden of the Gods Rd.
Colorado Springs CO 80907

By signing below, I agree that all of the information that I provided is correct and current. I acknowledge that EPCPH may contact me to ask me for more information about my request.

Print Name of Patient: ____ **Date:** _____/_____/_____

Signature of Patient or Patient Representative:

____

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For EPCPH Immunizations Use Only: Staff fulfilling request will initial this form indicating that identification has been verified in accordance with the EPCPH policy.

Date of Release of Records: _____/_____/_____ **Payment Amount (if required): $**__________

Date Payment Received: _____/_____/_____ **Initials of Immunizations Staff Fulfilling Request:** _____________

The original copy of this completed form is to be maintained in the client's record, along with any accompanying communication, action, or designation.