Patient Request for Access Form

This form is to be used when patients or their Personal Representatives request access to, or copies of, the patient's health record information. In addition, patients or their Personal Representatives may direct Children's Colorado to provide copies of the patient's information to any third party of their choosing. All requests for access or copies of records must be submitted in writing.

Incomplete or illegible requests may delay access to the requested records.

DEMOGRAPHIC INFORMATION (* denotes required information)	
*Patient's Full Name (Last, First, MI)	*Patient's Date of Birth
*Patient's Address (Street, City, State, ZIP)	*Requestor's Phone Number
*Other Name(s) Used:	Do you have a **MY CHART** account? ☐ Yes ☐ No

WHAT INFORMATION DO YOU NEED?

☐ **Designated Record Set** (includes ALL medical records)

- OR - Specify which records you are requesting below:

Hospital Records:	**Test Results or Reports:**	**Billing Records:**
☐ Inpatient records	☐ Audiology	☐ Itemized Statement
☐ Outpatient records	☐ Lab / Pathology Results	☐ Payments
☐ Emergency Department	☐ Cardiology Tests	☐ Claims
☐ Urgent Care	☐ Sleep Study Report	
☐ Surgery or Procedures	☐ Radiology Reports	**Images:**
☐ Pharmacy	☐ Immunization Record	☐ Radiology Images ☐ Other Images

☐ **Other Records** *(please specify)*:

*** Dates of Records Requested**: Start: / / End: / /

HOW WOULD YOU LIKE TO RECEIVE THESE RECORDS?

☐ **MyChart**	☐ **Email:**	☐ **PowerShare** (Radiology images only**)**

☐ **VIEW ONLY** (for requests to inspect or view your child's medical records at CHCO. You will receive a call within 2 business days to schedule an appointment.)

☐ **VERBAL ONLY** (you authorize your healthcare team to speak with a person of your choosing about the patient's health care. No copies of records will be released.)

☐ **FAX** records to: #: _____ Attn: _____

☐ **US Mail:** Name: _____

Address: _____ City/State/ZIP: _____

Pick up in person: please provide a phone # we can call when they are ready: _____

☐ Anschutz Medical Campus ☐ Colorado Springs Campus ☐ South Campus ☐ North Campus

☐ Paper copies
☐ CD

- Personal representatives will not be provided access to records of a minor for treatment if the minor was legally able to consent to treatment themselves unless the minor signs below allowing access to this information.
- Access may be denied if the information is not part of the designated record set or if it is determined the access could endanger or harm the patient or others. Please refer to CHCO's Notice of Privacy Practices.

Your Name *(please print)*:	**Relationship to Patient:**
Your Signature/Date:	**Patient Signature/Date:**

Send This Completed Form to Children's Hospital Colorado - Health Information Management
Email: ROI@childrenscolorado.org **Mail:** 13123 E. 16th Ave, Box 150, Aurora, CO 80045 **Questions:** 720-777-4259
Fax: 720-777-7251 (Anschutz) **or** 719-305-8705 (Colorado Springs)

Children's Hospital Colorado
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Place Patient Identification Label Here