PEDIATRIC ASSOCIATES OF DURANGO

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please print

Patient Name		Other Last Names
Date of birth	Phone Number	Email Address
Street Address		City, State, Zip code

Transfer of care is required due to the closing of my physician's office. Therefore, I hereby authorize

Morgan Records Management LLC, 159 Frontage Rd, Manchester, NH 03103,

on behalf of **Pediatric Assoc of Durango, 1199 Main Ave, Ste 205, Durango, CO 81301** to execute one of the following:

Please select one of the following delivery options:

☐ Secure HIPAA approved electronic transfer to patient or physician.
List email address here _____

☐ Disc mailed to home or physician. We mail USPS Certified Return Receipt. List address here:
_____

I, _____, am the patient or legal guardian who has authorization to release the above records. Any facsimile, copy, or photocopy of this release will be valid for 90 days and shall authorize you to forward my medical records. This form gives you permission to share my private information obtained from this facility. Only records from this facility can be legally released. Any records from other physicians must be obtained from them directly.

_____

Patient or Legal Guardian Signature Date

Your completed authorization form may be faxed to 603-509-3987, emailed to MHurley@MorganRM.com, or mailed to Morgan Records Management LLC, 159 Frontage Rd, Manchester, NH 03103.