



*Level One Care for ALL*

**To:** Correctional Care Administrators, Providers, Medical Records Staff and Other Clinical Partners  
**From:** Denver Health Correctional Care Department  
**Re:** Change in process for requesting health information from Denver Health  
**Date:** Effective October 15, 2007 Revised May 7, 2009

Based on a successful month-log trial project with the State DOC, DRDC and DWCF, the Denver Health Correctional Care Department is transferring all requests for medical record information to our U Health Information Management Department (HIM). In order to meet your 24/7 need for complete medical information on your patients, our HIM department has made it their goal to prioritize all requests coming from correctional facilities for stat responses.

We believe we have one of the finest HIM departments in the country, and we know they'll be able to provide you with the highest quality service.

Changes:

- All Release of Information (ROI) requests will go through Denver Health HIM department. This includes outpatient, emergency department or specialty clinic visit, as well as lab and radiology.
- Please type the attached template onto your company or facility letterhead for all faxed medical record requests, so we can provide more timely service.
- In order to assure continuity of care, we will continue to provide copies of your patient's medical records upon discharge and transfer to your facility.

**Denver Health HIM Phone Number 303 602-8000**

**HIM Fax Number 303 602-8003**

We appreciate your business, and continue to strive to improve our services. Please do not hesitate to call if you have any questions.

Terry Howard/RN/BSN  
Correctional Care Coordinator  
303 436-7164  
[Terry.Howard@dhha.org](mailto:Terry.Howard@dhha.org)

Karen Henderson  
HIM Manager  
303 602-8019  
[Karen.Henderson@dhha.org](mailto:Karen.Henderson@dhha.org)

Your letterhead

**Correctional Care Medical Records Request**

To: Denver Health HIM department

Fax Number: 303 602-8003

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ (aka) \_\_\_\_\_

Patient's Date of Birth \_\_\_\_\_

Patient's SS number, if available \_\_\_\_\_

Requested Date of Service \_\_\_\_\_

Specific requested documents \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Fax number \_\_\_\_\_

Name and title of requested \_\_\_\_\_

Phone Number \_\_\_\_\_