AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
To Have Records Released to Longmont Clinic

Section A. Complete for All Authorizations

I hereby authorize Longmont Clinic to use or disclose my individually identifiable health information (PHI) as described below. I understand that this authorization is voluntary. I understand that, if the organization authorized to receive my PHI is not a health plan or health care provider, the released PHI may no longer be protected by federal privacy regulations.

Patient Name: Date of Birth:

Persons/organizations authorized to **release** your PHI

_____
_____
_____

Persons/organizations authorized to **receive** your PHI

Longmont Clinic 303.776.1234
1925 West Mountain View Avenue 720-494-3111 Fax
Longmont Colorado 80501
ATTN: DR. _____

Specific description of PHI to be released:

___ Entire Medical Record
___ Most recent 3 Years
___ Most recent 5 Years
___ Immunizations
___ Laboratory Results, from date _____ to date _____
___ X-ray Reports, from date _____ to date _____
___ X-ray Films, specify type/date _____
Other: _____

Specific restrictions you want placed on the release of your PHI _____
_____
_____

Reason(s) copies are being requested:
___ Moving ___ Consultation ___ Changing Doctors ___ Changing Insurance ___ Other: _____

I understand that this authorization will expire one year from the date below or on (date) ___/___/___ Initials _____

I understand that I may revoke this authorization at any time by notifying the releasing organization in writing, but my Revocation will not affect any releases made or other actions taken before the date of my revocation. Initials
_____

I understand that for use other than continuing medical car, there will be a charge of $14.00 for the first ten pages, $.50 per page for pages 11 – 40 and $ .33 per page thereafter for copies of my medical records. This charge is due and payable at the time copies are obtained. Initials
_____

Section B: Complete for All Authorizations

_____
Signature of patient of patient's representative (*Form MUST be completed before signing*) **Date**

Printed name of Patients Representative: _____

Relationship to the Patient: _____

This form is not necessary to release information for treatment or payment purposes except if the information to be released is psychotherapy notes or certain research information.