

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION  
To Transfer Records From Longmont Clinic to Another Medical Provider**

**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  
1925 West Mountain View Avenue  
Longmont Colorado 80501  
Phone:303-776-1234/Fax:720-494-3111

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 care, 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 \_\_\_\_\_  
\_\_\_\_\_

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**Section B: Complete for All Authorizations**

Signature of patient or patient's representative (*Form MUST be completed before signing*) \_\_\_\_\_

Date \_\_\_\_\_

Printed name of Patient's 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.*

