



**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**(PLEASE PRINT)**

Phone Number: \_\_\_\_\_ Address: \_\_\_\_\_

Persons/organizations authorized to **release** your information: \_\_\_\_\_ Persons/organizations to **receive** your information: \_\_\_\_\_

**Clinic Name:** \_\_\_\_\_

Longs Peak Family Practice 303-772-5578 phone  
1309 Sunset Street 720-230-5413 fax  
Longmont, CO 80501 **Attn: Dr.** \_\_\_\_\_

Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_



Please tell us what information to release:

- \_\_\_\_\_ **Most Recent 3 Years\*\*PREFERRED\*\*** \_\_\_\_\_ Laboratory Results from date \_\_\_\_\_ to date \_\_\_\_\_
- \_\_\_\_\_ Most Recent Physical \_\_\_\_\_ X-Ray Reports, from date \_\_\_\_\_ to date \_\_\_\_\_
- \_\_\_\_\_ Entire Medical Record \_\_\_\_\_ Procedure Reports, from date \_\_\_\_\_ to date \_\_\_\_\_
- \_\_\_\_\_ Immunizations \_\_\_\_\_ What Procedure? \_\_\_\_\_
- \_\_\_\_\_ Other: \_\_\_\_\_

**\*\*\*It is ok to release mental health, substance abuse, and/or AIDS/HIV information.\*\*\***

**Please Circle and Initial on the line: YES NO \_\_\_\_\_ Initial**

Reason(s) copies are being requested:

\_\_\_\_\_ Moving \_\_\_\_\_ Specialist \_\_\_\_\_ Changing Doctors \_\_\_\_\_ Changing Insurance \_\_\_\_\_ Personal copy

By signing this form,

\*I understand that this authorization will expire one year from the date below or on (date) \_\_\_\\_\_\_\\_\_\_. 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.

\*I understand that for Personal Copy requests, there may be a charge for copies of my medical records.

\_\_\_\_\_  
Signature of patient or patient's legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of patient's legal representative

\_\_\_\_\_  
Relationship

Visit our web site at: [www.longspeakfamilypractice.com](http://www.longspeakfamilypractice.com)

Other/MedRelease/Solo

<b>Office Use Only</b> Imported/Faxed _____ By _____
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