AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

Patient Name: ________________________________ Date of Birth: ____________________
(PLEASE PRINT)
Phone Number: ____________________ Address: ____

Persons/organizations authorized to release your information:

Clinic Name: ______________________________________
Physician Name: ________________________________
Address: ______________________________________
City: __________________ **State:** ____ **Zip:** _________
Phone: ________________ Fax: _________________

Persons/organizations to receive your information:

Longs Peak Family Practice 303-772-5578 phone
1309 Sunset Street 303-772-8207 fax
Longmont, CO 80501 Attn: Dr.____________

Please tell us what information to release:
_____ Most Recent 3 Years****PREFERRED****
_____ Most Recent Physical
_____ Entire Medical Record
_____ Immunizations
_____ Other: ____
_____ Laboratory Results from date _______ to date _______
_____ X-Ray Reports, from date _________ to date _________
_____ Procedure Reports, from date _______ to date _________
Which Procedure? _______________________

*****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

FOR OFFICE USE ONLY:
Imported__________________By_____
Faxed____________________By_____
Rec'd____________________To______