Longs Peak Family Practice

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Address: _____

Persons/organizations to **release** your information:
Longs Peak Family Practice 303-772-5578 phone
1309 Sunset Street 303-772-8207 fax
Longmont, CO 80501

DO NOT FAX IF MORE THAN 25 PAGES

Persons/organizations authorized to **receive** your information:
Clinic Name: _____
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: longspeakfamilypractice.com

Office Use Only
Date received _____
Initials _____