AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Records to be released (Circle or Check):

☐FROM ☐TO	☐FROM ☐TO
Longmont Integrative Family Practice PLLC **2130 Mountain View Ave.** **Ste. 203** **Longmont, CO 80501** **Phone: 303-776-8847** **Fax: 303-776-8897**	**Name: _____** **Organization: _____** **Addr: _____** **_____** **City St Zip: _____** **Phone: _____** **Fax: _____**

I hereby authorize Longmont Integrative Family Practice 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:_____

Specific description of PHI to be released:

_____ Entire Record _____ Most Recent 3 Years _____Most Recent 5 Years

_____ Immunizations _____ Lab Result _____ X-Ray Reports

Specific Restrictions: _____

Reason copies are being requested: _____

I understand that this authorization will expire one year from the date below.

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 release made or other actions taken before the date of my revocation.

CHARGES FOR RECORDS

Requested by Patient or Personal Representative:	Requested by Other Designated Representative:
Pages 1-10 $16.50 Pages 11-40 $.50/pg Pages 40+ $0.33/pg Mailing fee: $6.00	Pages 1-10 $18.50 Pages 11-40 $.75/pg Pages 40+ $0.50/pg Mailing fee: $6.00

_____ _____

Signature of patient or patient's representative Date

_____ _____

Printed Name of Patient/Representative Relationship to Patient