Longmont Pulmonary and Critical Care

1551 Professional Lane, Suite 235

Longmont, Colorado 80501

Phone: (303) 651-5302 Fax: (303) 651-5303

AUTHORIZATION FOR RELEASE OF INFORMATION

**Section A. Complete for all authorizations:**

I hereby authorize the use or disclosure of 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 a healthcare 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:**

Longmont Pulmonary and Critical Care

1551 Professional Lane, Suite 235

Longmont, Colorado 80501

**Persons/Organizations authorized to receive your PHI:**

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

Specific description of PHI to be released: (Check)

\_\_ Chart Notes \_\_ Diagnostic Imaging \_\_ Labs

\_\_ Pulmonary Function Test \_\_ Sleep Studies \_\_ Entire Medical Record

Reason(s) copies are being requested: (Check)

\_\_ Moving \_\_ Consultation \_\_ Changing Physicians

\_\_ Other

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

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Signature of patient or patient’s representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Printed name of and relationship of the patient’s representative