Longmont Pulmonary and Critical Care Associates
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:

Persons/Organizations authorized to receive your PHI:
Longmont Pulmonary and Critical Care Associates
1551 Professional Lane, Suite 235
Longmont, Colorado 80501
Phone: (303) 651-5302 Fax: (303) 651-5303
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.

Section B. Complete for all authorizations

Signature of patient or patient's representative Date

Printed name of and relationship of the patient's representative