RELEASE OF INFORMATION

Rocky Mountain Family Practice
Phone 303-772-6244 Fax 303-702-1623
205 S. Main St. STE B Longmont, CO 80501

Name of Patient: ___________________________________DOB___________________

Facility or Provider where records will be released from:

____

Address:____

Fax: _______________________ Phone:_______________________________________

Facility or Provider where records will be released to:

____

Address:____

Fax: _______________________ Phone:_______________________________________

For the purpose of? _____________________________________

( ) Entire Medical Record ( ) Most recent 3 years of record
( ) Immunizations ( ) X-ray reports from date _______to date_____
( ) Laboratory Results from date___________ to date________________
( ) HIV/AIDS information from date_________to date________________
Other ____

I understand that the medical information released by this authorization may include information concerning treatment or physical and mental illness, alcohol/drug abuse and past medical history.

I understand that this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except
To the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.

I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. RMFP cannot condition treatment, payment, enrollment in the health plan or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I accept full financial responsibility for copying fees. Per Colorado Department of Public Health and Environment Regulations, the fee for copying requested document is $18.53 for the first 10 pages, $0.85 for pages 11-40 and $0.57 pages 40+. Shipping and applicable sales tax will also be charged. There is no charge for records sent to another health care provider.

Patient Signature _________________________________Date ___________________

Personal Representative's Name and Relationship (Attach legal documentation of Authority) ______________________________________Date___________________

PLEASE DO NOT FAX IF OVER 20 PAGES- PLEASE MAIL