AUTHORIZATION TO RELEASE PHI

I ____, give permission for

____ to discuss and/or

receive medical information, including medical records, concerning me from the

Longmont Clinic and the medical staff at Longmont Clinic.

This release is required to obtain medical information in accordance with the privacy

policy detailed in HIPAA (The Health Insurance Portability and Accountability Act of

1996).

This release _____does ______ does NOT include permission to release financial

information from the business office.

Patient Name: ____

Date of Birth: ____

Patient's Signature: ____

Date: ____

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

__________________ (today's date) _________initials

I understand that I may revoke this authorization at anytime 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. _________initials