Lone Mountain Wellness, LLC
Authorization for Disclosure of Health Information

Patient Name: _____

Date of birth: _____ Phone: _____

Email address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize Lone Mountain Wellness, LLC to release the specified medical records to the person(s) or organization(s) listed below:

Name: _____

Organization: _____

Address: _____

Phone: _____ Fax: _____

Information Requested

Please specify the records you are requesting (check all that apply):

- ☐ Most recent note
- ☐ Most recent procedure record
- ☐ Laboratory results
- ☐ Other (please specify): _____
- ☐ Billing Statements
- ☐ Complete record
- ☐ All Procedure Records
- ☐ Medical records from the following date(s): _____

Please indicate the reason for request:

- ☐ At request of the individual
- ☐ Continuing care
- ☐ Other (please specify): _____

Method of receiving records:

- ☐ Mail to the address above
- ☐ Pick up in person (while location open)
- ☐ Patient portal (if available)
- ☐ Email: _____
- ☐ Fax: _____

I understand and acknowledge all of the following:

- That I must fill out this form in its entirety to be valid, otherwise it may not be possible for Lone Mountain Wellness, LLC to release my health information due to the HIPAA privacy laws.
- That my health records may contain information related to sexually transmitted diseases, including HIV/ AIDS, as well as details about behavioral or mental health services and treatments for alcohol or drug abuse.
- I have the right to revoke this authorization at any time by providing a written statement of revocation to Lone Mountain Wellness, LLC records or billing staff. I further understand that the revocation will not take effect until Lone Mountain Wellness, LLC staff has received it, and that it will not effect uses and/or disclosures of my health information that Lone Mountain Wellness, LLC has made prior to its receipt.
- I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I understand that in order to and inspect and copy medical information, I must submit a request in writing to Lone Mountain Wellness, LLC's records or billing staff. If I request a copy of the information, I understand that Lone Mountain Wellness, LLC may charge a reasonable cost-based fee in accordance with applicable law to fulfill my request.
- Authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to receive additional treatment.
- Any release of my information may lead to unauthorized further disclosures, and the disclosed information might not remain protected by federal confidentiality laws. I understand and agree to waive those protections.
- Unless otherwise revoked in writing, this authorization will expire on the following date or event specified by me: _____.
  If I fail to specify a date or event, this authorization will be valid for 90 days from the date of signature unless revoked in writing.

By signing, below, I authorize the release of my medical records as specified above.

Patient signature: _____

Printed name: _____

Date: _____

For office use only:

Request received by:_____

Date received: _____

Date completed: _____

Processed by: _____