Hermit's Point Medicine, LLC

Jen Davies, LAc, MSTCM, NCMT **Andrew Davies, DNM, CBP, CHt**

720-629-4211

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, ________________________request and authorize the release of medical records to the named practitioner(s) This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care.
Hermit's Point Medicine, LLC does not offer reimbursement for records received.

NAME	**BIRTHDAY**
PHYSICIAN, LAB OR HOSPITAL AND PHONE NUMBER	**SSN**

Please send my medical information to the following:

- ☐ Hermits Point Medicine, LLC
  6650 S. Vine St., Suite 250
  Centennial, Colorado 80121
- ☐ jennifer@hermitspointmedicine.com
- ☐ andrew@hermitspointmedicine.com

By checking the spaces below, I authorize the above practitioners to release written records pertaining to the following information going back ___________ year(s). I also authorize Hermit's Point Medicine, LLC to provide the following information via telephone consultation.

- ☐ Medical records needed for continuity of care
- ☐ Diagnostic imaging reports
- ☐ OTHER
- ☐ Pathology reports
- ☐ Laboratory reports

SIGNATURE	**DATE**

I understand that certain information in these records cannot be released without specific authorization because of federal or state laws. By signing the spaces below, I specifically authorize the release of the following confidential information for us by Hermit's Point Medicine. I also authorize the Hermit's Point Medicine, LLC to provide the following information via telephone consultation.
PROVIDE TEST RESULTS, DIAGNOSIS, TREATMENT, REFERRAL AND HIGH RISK BEHAVIOR DOCUMENTATION
This information may not be further disclosed without the specific written authorization of the patient or guardian.

☐ MENTAL HEALTH Documentation Authorization for Release	**SIGNATURE**	**DATE**
☐ HIV/AIDS Documentation Authorization for Release	**SIGNATURE**	**DATE**

Federal Regulation 42 CFR Part 2 requires a description of how much and what kind of information is to be disclosed.
PLEASE PROVIDE A DESCRIPTION:

☐ DRUG/ALCOHOL Documentation Authorization for Release	**SIGNATURE**	**DATE**