OriginalMD
Patrick M. Long, MD, PLLC d/b/a OriginalMD

1601 E 19th Ave, Ste 6450
Denver, CO 80218
Phone (720) 575-0267 | admin@originalmd.com

Authorization to Release Health Information

For records sent FROM another provider or facility TO OriginalMD

Complete this form to authorize another practice or facility to release your health information to OriginalMD.

Instructions: use a separate form for each provider or facility releasing records. Return the signed form to OriginalMD and we will send it to the releasing provider, or give it to the releasing provider yourself.

1. Please provide your basic information

Full legal name

Other names used (optional)

Date of birth (MM/DD/YYYY)

Phone number

Patient ID or MRN at releasing provider (if known)

Address (street, city, state, ZIP)

2. Select who is authorized to release the records

Name, address, and contact information of the person or organization releasing the records

Name / Title / Organization

Address

City / State / Zip

Phone

Fax

3. I authorize OriginalMD to receive the records

OriginalMD (Patrick M. Long, MD)
Address: 1601 E 19th Ave, Ste 6450, Denver, CO 80218
Phone: (720) 575-0267 Fax: (303) 565-4574
Attention: Medical Records

Patient name

Date of birth (MM/DD/YYYY)

4. Specify the purpose and type of information to be released

Purpose of disclosure (select all that apply)

- [ ] Continuation of Care
- [ ] Legal
- [ ] Personal Use
- [ ] Other

If Other, describe the purpose

Authorization expiration date (optional - if left blank, this authorization automatically expires 180 days from the date signed)

Description of information to be used or disclosed (select all that apply)

- [ ] Clinic Summary / Consultation
- [ ] Procedure
- [ ] Laboratory Reports
- [ ] Complete Medical Record
- [ ] Genetic Information
- [ ] Other

If Other, describe the information to be disclosed

For treatment date(s)

5. Delivery of records to OriginalMD

Records will be sent directly to OriginalMD by the releasing provider using their standard secure transmission method (e.g., secure fax, secure electronic exchange, or mail).

NOTE: OriginalMD cannot guarantee the method by which the releasing provider will transmit your records. If you have questions about the releasing provider's transmission methods, please contact them directly.

- [ ] Acknowledge

6. Check the boxes below to authorize release of sensitive health information

I authorize the release of my health records that may include information indicating the presence of communicable or venereal diseases, which may include, but are not limited to: hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS or Human Immune Deficiency Virus (HIV).

- [ ] I authorize

I authorize the release of my health records that may include information about behavioral and/or mental health services and/or treatment for alcohol and/or drug abuse.

- [ ] I authorize

My treatment, payment, enrollment or eligibility for benefits may not be conditioned by signing this authorization. This request is made voluntarily and the information given is accurate to the best of my knowledge. I may revoke this authorization at any time in writing, but if I do, it will have no effect on actions taken prior to receiving the revocation. I understand that information disclosed pursuant to the authorization may be subject to disclosure by the recipient and is no longer protected by the HIPAA privacy rule. Without my express revocation, unless otherwise indicated above this consent will automatically expire 180 days from the date signed below.

- [ ] Acknowledge

Patient name

Date of birth (MM/DD/YYYY)

I understand that if my records include substance use disorder treatment records protected by 42 CFR Part 2, a separate authorization compliant with 42 CFR Part 2 requirements may be required before those records can be disclosed.

☐ Acknowledge

I understand that if my records include psychotherapy notes as defined by 45 CFR § 164.501, a separate authorization specifically for psychotherapy notes may be required before those records can be disclosed. Psychotherapy notes are defined under HIPAA (45 CFR § 164.501) as notes recorded by a mental health professional documenting or analyzing the contents of a conversation during a private, group, joint, or family counseling session that are maintained separately from the rest of the patient's medical record. Psychotherapy notes do not include medication prescription and monitoring, counseling session start and stop times, modalities and frequencies of treatment, results of clinical tests, or summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

☐ Acknowledge

7. Please read and sign to authorize the disclosure of your protected health information

I have read the above and authorize the disclosure of my protected health information as stated.

☐ I agree. ☐ I do not agree.

Patient or Authorized Representative signature

Date (MM/DD/YYYY)

Printed name of person signing

Relationship to patient (if signed by an authorized representative; describe authority, e.g., POA, guardian)

Patient's electronic signature shall have the same force and effect as an original signature and shall be deemed (i) to be "written" or "in writing" or an "electronic record", (ii) to have been signed and (iii) to constitute a record established and maintained in the ordinary course of business and an original written record when printed from electronic files.

FOR ORIGINALMD OFFICE USE ONLY

Date received

Staff initials

Date sent

☐ Copy given to patient

☐ Sent to releasing provider