



Ideal Family Healthcare, P.C.

Patient Request for Release of Protected Health Information

By my signature below, I request that the following Facility or Individual:

| | | | |
|------------------------------|---------|-------|----------|
| _____ | | _____ | |
| Facility or Individual Name | Address | | |
| (_____) _____ - _____ | _____ | | |
| Facility or Individual Phone | City | State | Zip Code |

release certain protected health information (PHI) about me to Dr. Sharp at:

Ideal Family Healthcare, PC
PO Box 4918
Woodland Park, CO 80866
Fax (719) 686-7449
Phone (719) 686-8844

This authorization permits the facility or individual specified above to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

- Office visit notes
- Laboratory results
- Surgery or procedure notes
- Radiology reports
- Vaccination Records
- Other _____

The information will be used for ongoing medical care at Ideal Family Healthcare, PC.

Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

Print Patient's Name Date

Print Name of Legal Guardian, if applicable