FLATIRON
FUNCTIONAL MEDICINE

400 S. MCCASLIN BLVD., STE. 210 - LOUISVILLE, CO 80027
PHONE 303-993-7910 - FAX 303-993-4674

Release of Medical Information

I, ______________________, (Date of Birth: ______________) give Flatiron Functional Medicine permission to share/discuss my medical information including:

- ☐ **ALL Medical Information (all of the following):**
  - ☐ Appointment information
  - ☐ Prescription medications and instructions
  - ☐ Supplements and instructions
  - ☐ Office visit summaries
  - ☐ Results of testing
  - ☐ Communications with our providers and staff

with the following people:

Name: ______________________ Relationship: ______________________
Phone: ______________________ Email: ______________________

Name: ______________________ Relationship: ______________________
Phone: ______________________ Email: ______________________

SIGNATURE: ______________________ **DATE:** ______________

ALL OF THE INFORMATION HEREIN WILL BE TREATED IN ACCORDANCE WITH ALL APPLICABLE CONFIDENTIALITY LAWS AND PRACTICES AND IS INTENDED SOLELY FOR THE USE OF FLATIRON FUNCTIONAL MEDICINE.