Rochester
Lifestyle Medicine, PLLC
Empowering you to live a happier, healthier life

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PATIENT INFORMATION REQUEST

Your patient has registered for Rochester Lifestyle Medicine's CHIP Revolution program. **CHIP Revolution** is a one-year medically-supervised program which begins with a 9 - 12 week intensive lifestyle modification period made up of 18 two-hour group sessions meeting approximately twice per week. Patients then meet once per month. There are six lab draws along with six personal sessions with a physician or nurse practitioner during the year. A variety of other support service are provided to your patient such as cooking classes, yoga, and meditation. CHIP encourages participants to work closely with their primary care physician throughout the program. Your patient will be told that if he/she is on routine medications for elevated blood pressure, elevated lipids, high blood sugar, heart medications, etc. that he/she should stay in close contact with you. Frequently, changes in lifestyle reduce the need for some of these medications. We will be sending you updates on your patient's progress throughout the program period. Additional program information is available on our website at RocLifeMed.com.

Please assist us completing registration by faxing the following information for the patient listed below:
1. Current medication list
2. Active problem/diagnosis list
3. Recent labs (glucose, lipid panel, hemoglobin A1c, etc.)

If you have any questions, please feel free to contact our office.

RELEASE OF RECORDS

Patient Name		Patient DOB	

For the purpose of my enrollment in the Complete Health Improvement Program (CHIP) and coordination of care with my Primary Care Physician, noted below, I authorize Rochester Lifestyle Medicine, PLLC to:

_X_ Receive copies of my medical records from:
_X_ Send copies of my medical records to:

Physician Name		Physician Phone	
Practice Address		Physician Fax	

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, or my authorized representative, request that personal protected health information regarding my care and treatment be released as noted on this form. I understand the following:

1. I understand that signing this authorization is voluntary.
2. I understand that I have the right to revoke this authorization at any time by writing to the health care provider noted above, except to the extent that such information has already been released.
3. I understand that this authorization does not authorize Rochester Lifestyle Medicine, PLLC to discuss the disclosed personal protected health information with anyone other than the provider listed above.
4. I understand that Rochester Lifestyle Medicine, PLLC will only receive medical records that are relevant to my enrollment in CHIP, and will only send medical records regarding my progress in CHIP.

_____ _____
Signature of patient or legal, authorized representative Date