AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

Person/Facility to *Provide* records: _____
(Name, address, phone#, fax#) _____
_____
(___)_____(___)_____

Patient Name: _____ **SSN#:** _____ **DOB:** _____

Physician or Facility to *Receive* records: **The Care Group, PC**
750 Potomac Street, 111
Aurora, CO 80011
Phone: (303) 343-3121
Fax: (888) 268-3486

I authorize the health care provider to release the information specified below to the organization, agency, or individual named on this request. **I specifically authorize the release of information regarding the following condition(s):**
(If any of the following apply, please initial, otherwise please put N/A)

Drug Abuse: _____ **Substance Abuse:** _____
AID/HIV: _____ **Psychological or Psychiatric conditions:** _____

Release these records: **Initials**

1. All records generated by this facility..... _____
OR
2. Only the dates of service or labs specified..... _____

(Please Specify): _____

I understand that I may revoke this authorization at any time. A copy of this authorization may be utilized with the same effectiveness as an original. **I understand that there may be a copying fee per the Colorado Department of Public Health and Environment.**

Patient's signature: _____ **Person authorized to sign for pt:** _____

Maiden Name: _____ **Signature:** _____

Date: _____ **Relationship to Patient:** _____

Date: _____

Reason for release (required):

_____ Moved/Moving _____ Dissatisfaction with Provider

_____ Dissatisfaction with Group Structure _____ Insurance change

_____ Other: _____

Are you transferring care? Yes _____ **No** _____