AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

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

Patient Name: ______________________________ **SSN#**: ________________ **DOB**: ____________

Person/Facility to receive records: ____
(Name, address, phone#, fax#) ____
____
(___)________________(____)__________________

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 ________