AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: ______________________________ **Date of Birth:** ______________________________

Person requesting records and relationship: ____

Home phone: ________________________ **Daytime/cell phone:** ______________________________

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

I authorize the disclosure/release of the following information:

___ All records
___ Laboratory/Pathology records
___ X-ray/Radiology records
___ Billing records
___ Abstract/Summary
___ Pharmacy/Prescription records
___ Other (describe specifically) ______________________________
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****Note:** If these records contain any information from previous providers or information about **HIV/AIDS** status, cancer diagnosis, drug or alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

Initial: __________ **Date:** ________________________

Limitations on the information you may release subject to this Release Form are as follows:

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Release Records from:	**Release Records to:**
Name: ______________________________	Transitions Chronic Care
Address: ______________________________	424 Kimbark Street
______________________________	Longmont, CO 80501
Phone: ______________________________	Phone: 303-427-5302
Fax: ______________________________	Fax: 720-475-1877

The reasons or purposes for this release of information are as follows:

____

Printed Name of Patient

____

Signature of Patient or Authorized Representative

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Date Signed

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