



PO Box 6020 Boulder, CO 80302
Phone: 720-878-1182 Fax: (888) 250-3291

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____
Previous Name: _____ Medicare #: _____

I request and authorize _____ to
release healthcare information of the patient named above to:

Name: Perfect Sense Care Management
Address: PO Box 6020
City: Boulder State: CO Postcode: 80302-6020

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates: _____
- All healthcare information
- Other: _____

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.