Internal use only: sent uploaded Med recon TOC

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Hertneky Vision Source
212 Cameron Street Brush, CO 80723
Phone 970.842.5166 Fax 970.842.5167
Direct address: Stephaine.Griggs@direct.revolutionehr.com
Stephaine Griggs, Privacy Official

Patient Name and DOB _____

Patient Address _____

Patient Phone Number _____

I authorize _____ to release health information identifying me (including, if applicable, information about substance abuse, mental health conditions, and HIV infection or AIDS) under the following conditions:

1. Detailed description of the information to be released: an electronic **Transition of care document that includes a current medication list, allergy list, and problem list.**

   Send the electronic TOC to Stephaine.Griggs@direct.revolutionehr.com

2. To whom may the information be released (name(s) or classes of recipients): **Hertneky Vision Source**

3. The purpose(s) for the release: **Medication Reconciliation**

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you may revoke it at any time by contacting in writing, FAX or email the Privacy Official noted in the *Notice of Privacy Practices*.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

Phone: Fax:

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Representative

Relationship to Patient

Phone:

Fax: