# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Today's Date: ___________________________

Patient Name: ____________________________________________

Patient Address: _________________________________________

Patient Telephone: ___________________ Patient DOB: ______________

I request and authorize the release of my medical records at Colorado Center for Dermatology, PLLC to the appropriate organization, agency, or individual named on this request. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it. If not revoked by me, this authorization will automatically expire in one year from today.

Please release Medical Records to:

☐ Medical Office ☐ Patient/Private Address** ☐ Non-Medical Office/Facility**

Name: ________________________________________________________

Address: ______________________________________________________

Telephone Number: ______________________________________________

Fax Number: ____________________________________________________

Email Address (if applicable): _______________________________________

Please include:

- ❏ All Records (including all notes, lab and pathology reports)
- ❏ Clinical Notes
- ❏ Lab and Pathology Results
- ❏ Other _________________________

___________________________________________________________________________

Patient/Representative Signature Date

________________________________ ____________________________________

Printed Name Witness Signature

** Requests for sending medical records to a private address or non-medical office/facility may be subject to fees determined by state law, contractual agreements, and/or office policies.