Denver Tech Center
7180 E. Orchard Rd, Suite 210
Centennial, CO 80111
Phone: (303) 761-0906
Fax: (303) 761-0907

Longmont
1350 Tulip Street
Longmont, CO 80501
Phone: (303) 761-0906
Fax: (303) 761-0907

MEDICAL RECORDS REQUEST FORM

Today's Date: ______________________________

Patient Name: ____

Patient Address: ____

Patient Telephone: _____________________ Patient DOB: _______________

I authorize the following physician or facility to release information:

Physician Name: _______________________________

Facility Name: _________________________________

Address: _____________________________________

Telephone Number: ____________________________ Fax Number: __________________________

Please release Medical Records to:

Colorado Center for Dermatology & Skin Surgery
7180 E. Orchard Road, Suite 210
Centennial, CO 80111
Phone: (303) 761-0906
Fax: (303) 761-0907

Please include:

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

I understand that my authorization will remain effective from the date of my signature for 365 days after, and that the information will be handled confidentially in compliance with all applicable federal laws. In addition, I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication. I have read and understand the nature of this release.

____

Patient/Representative Signature Date

___________________________________ ____

Printed Name Witness Signature