COLORADO CENTER for DERMATOLOGY & SKIN SURGERY

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 (preferred method to send via secure email):

_____

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.