COLORADO CENTER for DERMATOLOGY & SKIN SURGERY

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

8008 E. Arapahoe Ct., Suite 200

Centennial, CO 80112

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