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 Dermatology Group, 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: ______________________________

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.