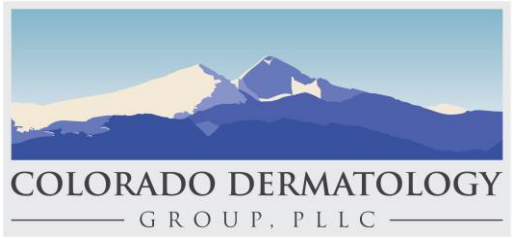


# MEDICAL RECORDS REQUEST FORM

**PATIENT NAME:** _____

**DOB:** _____

**DATE OF REQUEST:** _____

I authorize the following physician or facility to release information:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

☐ All Records (including all notes, labs and pathology reports)

☐ Clinical Notes

☐ Labs and Pathology Results

☐ Other: _____

**RELEASE MEDICAL RECORDS TO:**

Colorado Dermatology Group, PLLC
3609 S Timberline Rd Unit A
Fort Collins, CO 80525
Phone: (970) 305-4341
Fax: (970) 482-9948
info@coloradodermatologygroup.com
*www.coloradodermatologygroup.com*

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. This authorization will automatically expire in one year unless stated otherwise.

Signature: _____Date: _____ Printed Name: _____

If not signed by the patient, please indicate relationship: _____