Colorado Dermatology Institute

PATIENT-CENTERED SPECIALTY PRACTICE NCQA RECOGNIZED

MEDICAL RECORDS RELEASE

I, _____, request Colorado Dermatology Institute forward a copy of the following medical records:

___	Complete Medical Record	___	Medication Reports
___	Biopsy Reports	___	Medication Allergies
___	Laboratory Reports	___	Allergy Test/Treatment
___	Consultation Reports	___	Surgical Procedures

For date of service from _____ to _____

TO THE BELOW ADDRESS:

As applicable by law, I understand that there may be a copy and or fax fee applied for the above service.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

_____ _____
Witness Name (please print) Date

_____
Patient Date of Birth