MEDICAL RECORDS RELEASE

I, ____ (DOB:___________),
request that

Name: _________________________________ Telephone: ________________
Address: ________________________________ Fax:______________________
____

forward a copy of the following medical records to Colorado Dermatology Institute:

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

for date of service from ____________________ to _______________________

I authorize Colorado Dermatology Institute to obtain this requested information. Please call the office at 719-531-5400 with any questions regarding this release. This Medical Records Release request will expire one year from the date of this form being signed.

______________________________________ _______________
Signature of Patient or Legal Guardian Date

____
Print Name of Patient or Legal Guardian

______________________________________ _______________
Signature of Witness Date

____
Print Name of Witness