Colorado Dermatology Institute

MEDICAL RECORDS RELEASE

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

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

For date of service from _____ to _____

TO THE BELOW ADDRESS:

Name: _____ Telephone: _____
Address: _____ Fax: _____
_____

I understand and agree that I am financially responsible for the following fees associated with my request for protected health information: copying charges, including the cost of supplies and labor, and postage related to the production in the information. I understand that the charge for this service is $_____. 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