



affiliated with



Department of Dermatology
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

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

North Location: 8580 Scarborough Drive, Suite 225
Colorado Springs, CO 80920

South Location: 1220 Lake Plaza Drive
Colorado Springs, CO 80906

P: 719-531-5400 | F: 719-531-9545
www.coderm.com

Board Certified Dermatologists

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Dr. Jonathan Bielfield

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