affiliated with

Department of Dermatology
UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

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

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

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