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

8580 Scarborough Drive, Suite 225 | Colorado Springs, CO 80920
O: 719.531.5400 | F: 719.531.9545

1220 Lake Plaza Drive | Colorado Springs, CO 80906
O: 719.531.5400 I F: 719.896.4971

www.CoDerm.com