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: _______________

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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