AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name | Patient DOB | Acct # | Relationship (other than Self)

☐ I hereby authorize the Skin Cancer & Dermatology Center of Colorado Springs, P.C. to release medical information as described below to (Information must be complete)

Name of Facility: _____

Address: _____

Phone Number: _____ **Fax Number:** _____

☐ I hereby authorize _____ to release medical information to the Skin Cancer & Dermatology Center of Colorado Springs. Release medical records to:

1975 Research Parkway, Suite 165, Colorado Springs, CO 80920
OR Faxed directly to: 719-574-6574

Information to be released: (Please check all boxes that apply)

- ☐ The entire medical records. Initial here _____ to exclude documents relating to sexually transmitted disease, Aids, HIV, behavioral or mental health services, alcohol, and drug abuse. Otherwise, by checking the box, the entire medical record will be released.
- ☐ Lab Reports
- ☐ X-Ray Reports
- ☐ Biopsy Reports
- ☐ Consultation Notes
- ☐ Office Notes Only
- ☐ Other (Please Specify) _____

Expiration Date: _____. **The expiration date will be for one year unless otherwise noted.** By signing below, I authorized the release of **my** medical information or the medical information relating to my child and/or minor for whom I am the legal guardian.

_____ _____
Printed Name of Patient/Parent/Guardian | Printed Name of Witness

_____ _____
Signature of Patient/Parent/Guardian | Signature of Witness

_____ _____
Date | Date

1975 Research Parkway, Suite 165 / Colorado Springs, CO 80920 / (719) 574-0310 / FAX (719) 574-6574
www.SkinCancerAndDerm.com

revised 4.2020 tkd