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.
All medical records can be released to:

595 Chapel Hills Drive, Ste. 303
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) _____
  _____
  _____

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

Reviewed: 7/2017 tkd