Colorado Dermatology Specialists

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ DOB: _____

Above listed patient authorizes the following healthcare facility to release healthcare information to:

Colorado Dermatology Specialists
Midtown Location
1960 N Ogden St, Suite 555
Denver, CO 80218
Phone: 303-831-0400
Fax: 303-831-0417

Colorado Dermatology Specialists
South Denver Location
3540 S. Poplar St, Suite 300
Denver, CO 80237
Phone: 303-850-9715
Fax: 303-850-0649

Facility Name: _____

Facility Address: _____ City, ST, Zip: _____

Facility Phone: _____ Facility Fax: _____

This request and authorization applies to:

_____ All healthcare information

_____ Specific Information or dates requested: _____

Unless otherwise revoked, this authorization will expire 1 year from the date signed

Patient/Guardian Signature: _____ Date: _____