Colorado Dermatology Specialists

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ DOB: _____

Above listed patient authorizes Colorado Dermatology Specialists to release healthcare information to:

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: _____

Please note:

1. A copy fee may be assessed for medical records
2. HIPAA allows 30 days to process medical records
3. Unless otherwise revoked, this authorization will expire 1 year from the date signed

Patient/Guardian Signature: _____ Date: _____

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South Denver: 3540 S. Poplar St, Suite 300, Denver, CO 80237 P: 303-850-9715 F: 303-850-0649
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