AboutSkin
Dermatology and DermSurgery, PC

AUTHORIZATION TO RELEASE
ABOUTSKIN DERMATOLOGY MEDICAL RECORDS

Email Form to: info@aboutskinderm.com or Fax: 303-756-7547

Patient Name: ________________________________ Date of Birth _____/_____/_____

Phone #: (_______)______________________ May messages be left by phone? ☐ Yes ☐ No

I request and authorize to release the information regarding my treatment to the appropriate organization, agency, or individual named on this request. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it. If not revoked by me, this authorization will automatically expire one year from today's date.

_______ initials — I understand that the release of this information will no longer guarantee the confidentiality of the information disclosed. I release all physicians and staff at AboutSkin Dermatology from any and all liability concerning disclosure of this information.

_______ initials — I understand that Colorado state law (**C.R.S. 25-1-802**) allows up to 30 days from the date of this authorization for copies of my medical records to be provided. However, it is the policy of AboutSkin Dermatology to attempt to provide such records within two weeks after request has been received.

_______ initials — I understand that copies of medical records may incur a fee, per Colorado state law. Copies are provided free of charge if sent to a medical office. Patients requesting copies of their own medical records will be charged $10.00 for ten or less pages, $0.50 per page for pages 11-40, and $0.25 per page for 41 pages or more. Records sent to a non-medical office will be charged $16.50 for the first ten pages or less, $0.75 per page for pages 11-40, and $0.50 per page for 41 pages or more.

____ ____________________

Patient Signature (or Signature of Parent/Legally Authorized Person) Today's Date

____

If not patient, print name above and indicate relationship to patient

Release the following medical records: (Include Cosmetics: ☐ Yes ☐ No)

Last visit ☐

Past 6 months ☐

Past year ☐

Other ☐ Specify: ______________________________

Send copies of medical records to:

☐ Medical Office ☐ Patient / Private Address** ☐ Non-Medical Office**

Name: ____

Address: ____

City/State/Zip: ____

☐ *Send release by fax instead? If so, fax #:* (______)____________________________

**Payment Information (*required if records being provided to patient or non-medical office*):

☐ Call above phone # when copies are ready to arrange payment.

☐ Charge to credit card # ____________________________________

Expiration Date:__________________ Security Code/CCID #: ________

- - - - - -OFFICE USE ONLY / DO NOT WRITE BELOW -

Date Rec'd: _____________
Chart Loc: _________________
Provider(s): ________________

Approval From Provider(s) with Date:

Date Released: ___________