



# AUTHORIZATION TO RELEASE ABOUTSKIN DERMATOLOGY MEDICAL RECORDS

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: \_\_\_\_\_

Approval From Provider(s) with Date:

Date Released: \_\_\_\_\_

Chart Loc: \_\_\_\_\_

Provider(s): \_\_\_\_\_

[Signature Box]