ABOUT SKIN
DERMATOLOGY & AESTHETICS

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Authorization for the Release of Medical Records from AboutSkin Dermatology

Email form to: info@aboutskinderm.com or Fax to: (303) 756-7547

Patient Name: _____ **Date of Birth:** _____ **Telephone Number:** _____

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.

Please initial:

_____ 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.

_____ 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 the request has been received.

_____ I understand that copies of my 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 pages for pages 11-40, and $0.25 per page for pages 41 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. I understand that AboutSkin must receive the required payment prior to processing my medical records.

_____ _____

Patient Signature (or signature of Parent/Legally Authorized Person) **Date**

_____

If not patient, print name about and indicate relation to patient

Release the following medical records: ***(include cosmetics:*** ☐ ***Yes*** ☐ ***No)***

Last Visit: ☐

Past 6 Months: ☐

Past Year: ☐

Other: ☐ _____

Send copies of medical records to:

☐ **Medical Office** ☐**Non-Medical Office**

Name: _____

Address: _____

Fax Number (*office to complete*): _____

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

☐ Call phone number provided above when records are ready to be processed.

☐ Credit Card #: _____ Expiration Date: _____ Security Code: _____