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Authorization for the Release of Medical Records to AboutSkin Dermatology

Patient Name: _____

Patient Date of Birth: _____

Patient Address: _____

Telephone Number: _____

I authorize the following physician or facility to release my medical records:

Physician/Facility Name: _____

Physician/Facility Address: _____

Physician/Facility Telephone Number: _____

AboutSkin Dermatology & DermSurgery, PC
5340 S. Quebec St. Suite 300S
Greenwood Village, CO 80111

All records: _____

Notes: _____

Lab Results: _____

HIV: _____

Signature of patient/patient guardian

Date

Witness

Date

Physician/Facility Fax Number: _____