Authorization for release of medical information

Patient name : _____ (Last name) _____ (Mid name) _____ (First name)

Your birthday : __/__/____ Telephone #: (___) - ___ - ____ E-mail : _____

Address : _____ APT #: _____ City : _____ State : _____ Zip : _____

☐ I authorize the following Physician or Facility to release information

Physician name : _____ Telephone #: (___) - ___ - ____ Fax #: (___) - ___ - ____

Address : _____ City : _____ State : _____ Zip : _____

Please release Medical Records to : AboutSkin Dermatology and DermSurgery, PC
5340 S. Quebec St., Ste. #300
Greenwood Village CO 80111
Telephone : 303-756-7546
Fax : 303-756-7547

Record to release : ☐ All Records ☐ Physician Notes ☐ Lab Results ☐ HIV

Patient Signature (Patient/Patient Guardian) : _____ Today's Date : _____

Witness : _____