DERMATOLOGY SPECIALISTS
SURGICAL · MEDICAL · COSMETIC

T 303-442-6647 F 303-442-2696 WWW.DSDERM.COM

Conscientious care delivered, together

Medical Record Release

Today's Date: _____ Patient Name: _____

Date of Birth: _____/_____/_____ (If applicable, previous name_____)

I. My Authorization: (*Check which applies*) **You may use or disclose the following health care information**

- ☐ All my health information…
  - ☐ maintained by Dermatology Specialists
  - ☐ maintained by_____
- ☐ My health information relating to the following treatment / condition:
  _____
- ☐ My health information only for these date(s):
  _____

(*Check which applies*) **You may use or disclose this health information to:**

- ☐ TO: _____
  Address: _____ City: _____ State: _____ Zip: _____
- ☐ **TO: Dermatology Specialists** | Ph#: 303-442-6647 | Fax #: 303-442-2696

(*Check which applies*) **Reason(s) for this authorization:**

- ☐ At my request
- ☐ Other (please specify: _____

II. My Rights: (*please read & sign below*)

I understand I do not have to sign this authorization form in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study OR To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form (form is available from the office) OR Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____

(*patient/legal guardian signature*) (*relationship to patient*)

_____ _____

(*patient/legal guardian printed name*) (*date*)