Briargate Location
8890 N. Union Blvd
Suite #207

Monument Location
17230 Jackson Creek Pkwy
Suite #200

SUMMIT DERMATOLOGY

www.summitdermatology.com

Phone: **719-667-0888**
Fax: 719-667-0808

Authorization to Release Medical Records

Patient Name: _____ Date of Birth: _____
Address: _____
Preferred Phone: _____

I authorize Summit Dermatology, P.C. to release the following protected health information:

- ☐ Complete Medical Record
- ☐ Biopsy Report(s)
- ☐ Lab Report(s)
- ☐ Consultation Report(s)
- ☐ Medication Allergies
- ☐ Allergy Test/Treatment
- ☐ Surgical Procedure(s)
- ☐ Other _____

Please check one:
☐ For all dates of service
☐ For dates of service from _____ to _____

Release to:
☐ Patient *(Mail or Office pick up)*
☐ Parent/Legal Guardian *(Mail or Office pick up)*
☐ Release my medical information to:
Provider Name/Facility: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation.
- Summit Dermatology, P.C. may charge a reasonable medical records copying fee as permissible by law.

_____ _____ _____
Patient Signature Printed Name Date

_____ _____
Parent/Legally Recognized Representative Signature Relationship to Patient