Briargate
8890 N. Union Blvd, Suite 207
Colorado Springs, CO 80920

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 the following provider or facility below to release the selected protected health information to Summit Dermatology, P.C.

Release From:

Provider Name/Facility _____

Provider Phone: _____ / Fax: _____

- ☐ Complete Medical Record
- ☐ Biopsy Report(s)
- ☐ Lab Report(s)
- ☐ Consultations 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)*
- ☐ Patient *(Office pick up)*
- ☐ Parent/Legal Guardian *(Mail)*
- ☐ Parent/Legal Guardian *(Office pick up)*
- ☐ Release my medical information to: Summit Dermatology, P.C.
  8890 N. Union Blvd, Suite 207
  Colorado Springs, CO 80920
  Phone: 719-667-0888 / Fax: 719-667-0808)

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/Parent/Legal Guardian **Printed Name** Relationship to Patient

_____ _____

Patient/Parent/Legal Guardian **Signature** Date