Rocky Mountain
DERMATOLOGY

REQUEST FOR RECORDS RELEASE

Date _____

Patient Name _____ DOB _____

Previous Name (if applicable) _____ Social Security # XXX-XX-_____

Please release medical records FROM:

Physician's Name _____ Facility Name _____

Address _____ City _____ State _____ Zip_____

Phone # _____ Fax # _____

Please release the following:

- ☐ All records
- ☐ Laboratory Records
- ☐ Other _____
- ☐ Pathology Records
- ☐ Surgical Records

Additionally, please include the following specified records:

- ☐ Birth Control/Family Planning
- ☐ Comprehensive Medication History
- ☐ Genetic Diseases
- ☐ HIV/AIDS
- ☐ Psychiatric Evaluations
- ☐ Sexually Transmitted Diseases
- ☐ Substance Abuse
- ☐ Billing records

Please forward medical records TO:

☐ Rocky Mountain Dermatology 2400 Spruce Street Suite 101 Boulder CO 80302
Phone (303)444-0833 Fax (303)444-0803

Physician's Name _____ Facility Name _____

Address _____ City _____ State _____ Zip_____

Phone # _____ Fax # _____

This authorization expires _____ and may not be valid for greater than a year.
Date/event

I know that I have the right to revoke this authorization at any time. Additionally, I understand that I must revoke this agreement in writing. I am aware that any information released before I revoke this authorization will not apply to the revocation. I realize that any disclosure of information carries with it the potential for re-disclosure and that the information may not be protected by federal confidentiality regulations. Signing this authorization is a voluntary decision and I can refuse to sign this agreement. By signing this release, I authorize the individual, organization, or agency specified on this request to release the medical record information noted above.

Patient/Legal Representative Signature _____ Date _____

Legal Representative Name _____ Relation _____

Records **from** our office approved _____ Date _____