

ALTA VISTA DERMATOLOGY

206 W. County Line Road, Suite 340
Highlands Ranch, CO 80129

MUST BE RETURNED

WITH PHOTO ID

Authorization for Release of Medical Information

I hereby authorize the release of information from the medical record of:

Patient Name: _____ Date of Birth: ____/____/____
Social Security No.: _____ Daytime Phone: _____

Information Released To:

From:

Alta Vista Dermatology
206 W. County Line Road, Suite 340
Highlands Ranch, CO 80129

Please Release the Following:

- Office visit notes
- All records
- Pathology reports
- Other (Specify) _____
- Lab Reports

Purpose of Need for Disclosure:

- Continued Patient Care
- Insurance Claim/Application
- Other (Specify) _____
- Personal Use
- Disability Determination
- Attorney/Legal

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

Signature of Patient or Legal Representative

Date

Relationship to Patient

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Alta Vista Dermatology liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative

Date

Relationship to Patient