ALTA VISTA DERMATOLOGY

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

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:
Alta Vista Dermatology, LLC.
206 W. County Line Road, Suite 340
Highlands Ranch, CO 80129
P: 303-888-6426 Fax: 303-302-1659

From:
_____
_____
_____
_____

Please Release the Following:

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

Purpose of Need for Disclosure:

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

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