Medical Records Release

I authorize the release of my medical records from: ____

Fax #: ________________________

Patient name: ____ Date of birth:__________________

Previous name: ____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All my health information maintained by the above-named practice

☐ My health information relating to the following treatment or condition: _________________________________

☐ My health information for the date(s):____

You may disclose this health information to:

Hill Center for Dermatology PC

17560 S Golden Rd, Suite 100

Golden, CO 80401

Fax: 303-278-0611

This authorization ends*: ☐ On (date): __________________

If no end date is provided, this authorization will expire one year from the date of signing

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility for benefits).

I may revoke this authorization in writing. If I revoke this authorization, it would not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Once the office discloses health information, the person or organization that receives it may be able to redisclose it. Privacy laws may no longer protect it.

____ __________________

Patient or legally authorized individual signature Date

____ _______________________________________

Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)