Accent Dermatology

350 Indiana Street Suite #500
Golden, CO 80401

Phone: (303) 463-9600
Fax: (303) 403-9919

REQUEST FOR RELEASE OF MEDICAL RECORDS

I authorize the disclosure of health information for the individual named below:

Patient Legal Name:_____ Date Of Birth:_____

Address: _____ Phone Number:_____

Description of information that may be used/disclosed (check all that apply):

☐ Entire Record	☐ Medical History
☐ Biopsy Report(s)	☐ Treatments
☐ Lab Report(s)	☐ Medications
☐ Consultation Report(s)	☐ Surgical Procedures
☐ My health Information for the date(s):_____	Other: _____ _____

This information may be disclosed to and used by the following individual or organization:

Records are requested:

☐ To or ☐ From

Accent Dermatology
350 Indiana St Suite 500
Golden, CO 80401
Phone: (303) 463-9600
Fax: (303) 403-9919

To be disclosed:

☐ To or ☐ From (Include name, complete fax & phone numbers)

_____
_____
_____
_____
_____

I understand I do not have to sign this authorization form in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

- To take part in a research study **OR**
- To receive health care when the purpose is to create health information for a third party.
- I may revoke this authorization in writing by writing a letter to the office. If I do, it will 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 re-disclose 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, etc.)