DENVER SKIN DOCTORS

# Authorization for Release of Information

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Information
Name _____

Address: _____

Date of Birth _____

I authorize the release of my medical information **from** (name of clinic/doctor/phone/fax)_____
_____
_____

Please select the information you would like to release:

__ All records
__ Visit notes
__ Histopathology reports
__ Imaging reports
__ Laboratory reports
__ Other (please specify) _____

Release information **to**:

_____

_____

_____

Purpose(s) of This Disclosure:
__ Continued Care
__ Insurance
__ Legal
__ Disability Determination
__ Personal
__ Other (please specify) _____

This authorization lasts for one year after the date of signature. It may be canceled in writing at any time. I understand that this authorization is voluntary and I may refuse to sign. My signature below indicates I have read and understand this form. I authorize the release of information as indicated above.

Signature of patient/Patient representative_____

Date_____

Name (please print)_____