Denver Dermatology Consultants, P.C.

Authorization of Release of Patient Records

Patient Name_____

Date of Birth _____

Social Security#_____

Phone Number_____

Release To:_____ Release From:_____
_____ _____

Address: _____ _____
_____ _____

I request and authorize the release of information to the organization, agency, or Individual named above. I understand that the information to be released may include the following condition(s).

1. Drug abuse/alcohol abuse(Federal Regulation 42 C.F.R.,Part 2).
2. Psychological or Psychiatric conditions.
3. A test for the presence of antibodies(HIV)/virus which causes AIDS.
4. An AIDS diagnosis and/or an AIDS related conditions.
5. Any third party source(i.e. Hospital, Specialist, Laboratory).

Information requested (Please initial all items you authorize to be released):

_____ Doctor Notes _____History&Physical _____Diagnostic Study
_____ XRay Reports _____ Lab Reports _____AIDS/HIV Info
_____ Path Reports _____Third Party Record _____Psych Evals
_____ Drug/Alcohol _____Other_____
Treatment Dates:_____
Purpose of Release:_____

_____ _____
Date Signature of Patient

_____ _____
Witness Signature of Legal/Guardian/Executor