# vail | aspen | breckenridge | glenwood dermatology

PO Box 2736/1140 Edwards Village Blvd, B200, Edwards, CO 81632 | p. 970.926.9226 f. 970.926.8755

Patient Name:_____Date of Birth: _____

**AUTHORIZATION FOR THE RELEASE AND/OR OBTAIN PATIENT INFORMATION**

| Obtain From: (Releasing Facility) | Release To: (Receiving Entity) |
|---|---|
| Name: | Name: |
| Address: | Address: |
| Phone: | Phone: |
| Fax: | Fax: |

I hereby give the releasing facility permission to disclose my individually, identifiable health information as listed below. I understand that once this information is disclosed, it may no longer be protected by Vail Dermatology. I understand that this authorization is voluntary, that further treatment cannot be conditioned upon signing this authorization.

**INFORMATION TO BE RELEASED** (check all that apply)
Date of Service range (month/year) From:_____To:_____

| | | |
|---|---|---|
| ___Emergency Room Report | ___Mental Health Treatment | ___Genetic Information |
| ___Discharge Summary | ___Drug/Alcohol Treatment | ___HIV/AIDS |
| ___Operative Report | ___Radiology Reports | ___Other |
| ___History & Physical | ___Laboratory Results | _____ |
| ___Clinic/Progress Notes | ___Other Test Results | _____ |
| ___Immunization Records | | |

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**AUTHORIZATION**: I understand that I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand that this consent will expire 190 days from the date of my signature unless I provide notice in writing that it should be revoked. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy of facsimile of this form is to be considered as valid as the original.

_____ _____
Signature of Patient or Authorized Representative Date of Signature

_____ _____
Printed Name Relationship to Patient (if applicable)

**PATIENT'S ACKNOWLEDGEMENT OF ACCESS TO MEDICAL RECORDS**
I hereby acknowledge that I the patient/authorized representative have inspected_____and/or received_____photocopies of the medical records from Vail Dermatology for the above named patient.

_____ _____ _____ _____
Date Signature Date Witness