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		

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