clarity
DERMATOLOGY
skin • cosmetic • vein • mohs surgery

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name ____________________________________ Patient DOB _________________

Name/Relationship of Requesting Person (if other than Self) ___________________________

❑ I authorize the following medical provider to release my medical information to Clarity Dermatology, PLLC.

Name of Doctor/Facility: ____

Address: ____

Phone Number: ____________________________ Fax Number: ________________________________

All medical records can be mailed or faxed to:

Address: 4350 Limelight Ave, Suite 205, Castle Rock, CO 80109
Fax: 720-686-7544

Information to be released: (Please check all boxes that apply)

❑ Complete Medical Record
❑ Visit/Office Notes
❑ Pathology Reports
❑ Lab Reports
❑ Radiology Reports
❑ Other (Please Specify) ____

_________ Please initial here to exclude documents relating to sexually transmitted disease, HIV, behavioral or mental health services, alcohol and drug abuse.

-- **OR** --

❑ I hereby authorize Clarity Dermatology, PLLC to release medical records to:

Name of Doctor/Facility: ____

Address: ____

Phone Number: ____________________________ Fax Number: ___________________________________

By signing below, I authorized the release of my medical information, or the medical information relating to my child and/or minor for whom I am the legal guardian.

________________________________	________________________________	________________
Printed Name of Patient/Parent/Guardian	Printed Name of Witness	Date
________________________________	________________________________	________________
Signature of Patient/Parent/Guardian	Signature of Witness	Date