AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Advanced Dermatology and Cosmetic Surgery located at 950 East Harvard Ave Suite 440 Denver, CO 80210 to release the following information to Core Dermatology for transfer of medical care.

Patient Name:_______________ Date of Birth: _______________

Address:_______________ Phone Number: _______________

City:_______________ State:_________ Zip: _______________

I authorize the release of the following protected health information:

- My entire medical record from _______________(name of previous practice).
  Please note this may include notes detailing behavioral health care/psychiatric care, alcohol and/or drug abuse treatment, AIDS/HIV and other communicable disease information, unless specifically excluded. Please exclude: _______________
- My health information related to the dates:_______________

Please send my records directly to Core Dermatology FAX: 833-615-8210

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment, payment or enrollment for health care.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation.
- I may see and obtain a copy of the information described on this form if I request it.
- I may request a copy of this form after I sign it.
- A copy fee may be assessed for medical records.
- HIPAA allows 30 days to process medical records.
- This authorization expires on___/___/___[if date not completed, one year after signed].

_______________ Signature of Patient / Representative

_______________ Date

If the patient listed above is a minor or is unable to sign, and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_______________ Signature of Patient / Representative

_______________ Relationship to patient

CORE DERMATOLOGY

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