CORE DERMATOLOGY

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Core Dermatology to release my information to the following physician/practice,

_____(name/address/fax)
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 Core Dermatology.

  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:_____

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

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CORE DERMATOLOGY

425 South Cherry Street, Suite 907• Denver, CO 80246
tel • 303-355-3000 fax • 833-615-8210 email • hello@mycorederm
www.mycorederm.com