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Boulder, Colorado 80304

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1708 N. Boise Avenue
Loveland, Colorado 80538

Medical Records Release Form

By signing this form, I authorize you to use and disclose my protected health information.

Patient Name:_____ Date of Birth:_____

RELEASE MY RECORDS *FROM:*

Name:_____

Address:_____

Phone #:_____ Fax #:_____

_____ All Medical Records
_____ Medical Records for the following condition
_____ Medical Records from dates: From:_____ To:_____

SEND MY RECORDS *TO:*

Name:_____

Address:_____

Phone #:_____ Fax #:_____

I understand that I have the right to revoke this authorization at any time by sending a written notification to Ideal Dermatology. I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. A revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

HIV/AIDS: I DO____DO NOT ___consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.

Printed Name:_____ Date: _____

Signature of patient/Personal Representative:_____