17560 South Golden Road, Suite 100 Golden, CO 80401
Phone (303)526-1117 | Fax (303)278-0611

Medical Records Release

Patient name: _____ Date of birth:_____

Previous name: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All my health information maintained by the above-named practice

☐ My health information relating to the following treatment or condition: _____

☐ My health information for the date(s):_____

You may disclose this health information to:

Name (or title) and organization_____

Fax: _____

OR

Address: _____City _____State _____Zip_____

OR

Email: _____ ☐ Encrypted ☐ Unencrypted**

***Hill Center for Dermatology cannot guarantee the security and confidentiality of an e-mail transmission. Employers and on-line service providers have the right to access and archive e-mail transmitted through their systems. If your e-mail is a family address, other family members may see your messages, therefore, please be aware that you use e-mail at your own risk. Because of the many internet and e-mail factors beyond our control, we cannot be responsible for misaddressed, misdelivered or interrupted e-mail. Your health care provider is not liable for breaches of confidentiality caused by yourself or a third party.*

This authorization ends*: ☐ On (date): _____

If no end date is provided, this authorization will expire one year from the date of signing

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility for benefits).

I may revoke this authorization in writing. If I revoke this authorization, it would not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Once the office discloses health information, the person or organization that receives it may be able to redisclose it. Privacy laws may no longer protect it.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)