Denver Tech Dermatology Associates PC

Medical Records Release - Authorization for Use or Disclosure of Protected Health Information

Patient Information:	Patient Name:	Date of Birth:
	Address:	
	Phone #:	

I authorize the Physician/Medical Practice listed below to disclose/release the following information:

☒ All Records for all dates of service

☐ To:
☐ From:

Person/ Facility:		
Address:		
Phone #:	Fax #:	

☐ To:
☐ From:

Denver Tech Dermatology Associates, P.C.
5889 S. Greenwood Plaza Blvd. Suite 250 Greenwood Village, CO 80111
Phone: 303-222-9559
Fax: 303-222-9557

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

The information may be used/disclosed to ensure continuity of care and for health maintenance purposes.
I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature of patient (or patient's Personal representative) Date
(i.e. parent, guardian, power of attorney for healthcare, executor)