Elevated Dermatology
SKIN CANCER SURGERY CENTER

10345 Parkglenn Way, Suite 100
Parker, CO 80138
Phone: (720) 851-5200
Fax: (720) 851-5222
www.elevatedderm.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Today's Date: _____
Patient's Name: _____
Patient's Address: _____
Patient's Telephone Number: _____ Patient's DOB: _____

I hereby request and authorize the release of my medical records to Elevated Dermatology and Skin Cancer Surgery Center, PC at 720-851-5222 (fax). I understand that I may revoke my authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization. If not revoked by me in writing, this authorization will automatically expire in one year from today.

Requesting my records be released from the following business:

Name: _____

Address: _____

Telephone Number: _____

Fax Number: _____

Please include:

- o All Records (including all notes, lab results and pathology reports)
- o Clinical Notes
- o Lab and Pathology Reports
- o Other _____

_____ _____
Patient/Representative's Signature Date

_____ _____
Patient's Printed Name Witness's Signature