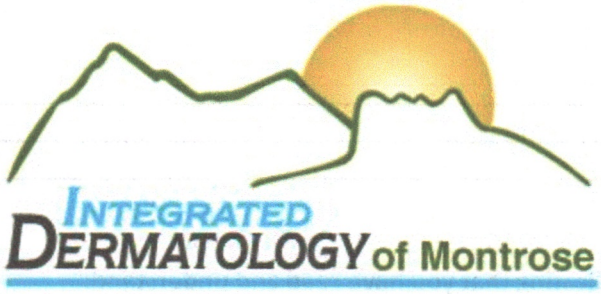

AUTHORIZATION TO RELEASE MEDICAL RECORDS

The purpose of this form is to provide the patient with information related to the legal release of patient health information (PHI) to Integrated Dermatology of Montrose. This PHI is used by Integrated Dermatology of Montrose for the treatment, payment, or healthcare operations. PHI is not used for marketing purposes.

Patient's (full) Name: _____
Patient's Date of Birth: _____
Patient' (newest) Address: _____

Section I

- ❑ **I, the undersigned, authorize the release of medical records as follow (check one):**

Only records that apply to treatment dates of _____to _____, excluding records that apply to substance abuse, mental illness, and communicable diseases including, however not limited to HIV/Aids for the dates listed above.

- ❑ **All records for the dates of service excluding records that apply to substance abuse, mental illness, and communicable diseases including, however not limited to HIV/Aids for all dates of service.**

- ❑ **Voluntary Opt In. Check only if desired.**

Additionally, I authorize disclosure of records that apply to substance abuse, mental illness, and communicable disease including, however not limited to HIV/Aids for the period s indicated above.

Section II

The above information is to be released to (Check if applicable):

- ❑ **Integrated Dermatology of Montrose**
  3480 Wolverine Drive, Suite F Montrose, Colorado 81401

Confidential Fax: 970-252-3446 Phone: 970-252-7444

- ❑ **Other individuals and/ or organizations who may receive your PHI. (Note: Spouses, children, etc. must be listed by name to receive you PHI.)**

Name: Facility/person **Provider /Relationship**

_____

_____

_____

Section III

Please check each box indicating that you have read and understand:

- ❑ **I understand that my records are confidential and cannot be disclosed without my voluntary and written authorization, except when otherwise permitted by law.**
- ❑
- ❑ **Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.**
- ❑
- ❑ **This authorization is valid _____(beginning date), through _____ (end date). NOTE: If no beginning or end date is listed this authorization automatically expires six (6) months from the signature date.**
- ❑
- ❑ **I understand that I may revoke this Authorization in writing at any time, except to the extent that action has been taken in reliance upon the authorization.**
- ❑
- ❑ **I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies.**
- ❑
- ❑ **I hereby release Integrated Dermatology of Montrose and its practitioners from all liability which may arise because of my authorized release of records.**

_____ _____

Signature of Patient **Date**

Or

_____ _____

Printed Name of Legally Authorized Representative (1) **Date**

_____ _____

Signature of Legally Authorized **Date**

(1) Please submit Power of Attorney, proof of guardianship, etc. (if applicable).