Peak Dermatology

2009 W. Littleton Blvd. Suite 100
Littleton, CO 80120

Authorization for Release of Medical Information

I hereby authorize the release of information from the medical record of:

____________________	____________________
Patient Name	Date of Birth
____________________	____________________
Primary Phone Number	Social Security No. (Last Four Digits)

From (Physician/Practice):

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____
____

Information Released To:
Peak Dermatology
2009 W. Littleton Blvd. Suite 100
Littleton, CO 80120
P: 303-221-4448 Fax: 720-287-6235

Please release the following information:

Office visit notes, pathology reports, lab reports and all records pertinent to continued patient care.

I understand that this information released will be used to ensure continuity of care and for health maintenance purposes. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time.

____________________	____________________
Signature of Patient or Legal Representative	Date

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Relationship to Patient