RENEW DERMATOLOGY

AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

I authorize the release of my medical records from RENEW DERMATOLOGY to the organization or provider listed below:

Provider's Name: _____

Provider's Address:_____

Provider's Phone #: _____ Fax # of Provider: _____

Reason for Disclosure of Records:_____

PATIENT INFORMATION

Patient's Name: _____Date Of Birth: _____

Address:_____State:_____Zip Code:_____

Social Security # (last 4 digits): _____Phone#:_____

The type and amount of information to be disclosed is initialed as follows: (specify dates where appropriate)
____Most recent 2 years of Records
____Entire Medical Records on file including but not limited to office visits, procedures, signed consents, and any referral provider notes.
____Most Recent labs or pathology reports within past 2 years
Other:_____

I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that treatment, payment, enrollment or eligibility of benefits will not be conditioned in obtaining your authorization for release of records. I accept full financial responsibility for any copying or shipping fees and any applicable sales tax that may be charged. Pre-payment is required for **printed** release of records to the individual patient for personal use at a rate of $14.00 for the first 10 pages then $0.50 per page for each additional page after that. Please note that requests will be completed within 30 days from date of signing this form.

_____ _____

Patient's Name Printed **Today's Date**

_____

Patient's/Parent's/Legal Guardian's Signature

_____ _____

Parent/Guardian/Representative **Relationship to Patient**

TOLL FREE
844-4RENEWME

OFFICE
970-409-4000

info@renewdermatology.com
www.renewdermatology.com

Renew DERMATOLOGY
"Renew The Skin You're In"

PHYSICAL ADDRESS
60 MAIN STREET, STE H
FRISCO, CO 80443

MAILING ADDRESS
265 DILLON RIDGE RD, STE C402
DILLON, CO 80435

RENEW DERMATOLOGY

AUTHORIZATION TO RECEIVE MEDICAL RECORDS/INFORMATION

I authorize the release of my medical records by the organization or physician listed below:

Provider's Name: _____

Provider's Address: _____

Provider's Phone #: _____ Fax # of Provider: _____

Reason for Records Release: _____

These records are to be sent to RENEW DERMATOLOGY at the following address and/or fax number:
60 Main Street, Suite H, Frisco, CO 80443. Fax number: 855-839-5617. Please call 970-409-4000 as needed.

Patient's Name: _____Date Of Birth: _____

Address: _____State: _____ Zip Code: _____

Phone #: _____

The type and amount of information to be disclosed is initialed as follows: (specify dates where appropriate)
____Most recent 3 years of Records
____Entire Medical Records on file including but not limited to office visits, procedures, signed consents, and any referral provider notes.

I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I accept full financial responsibility for any copying or shipping fees and any applicable sales tax that may be charged.

_____ _____

Patient's Name Printed **Today's Date**

_____

Patient's Signature

_____ _____

Parent/Guardian/Representative **Relationship to Patient**