MONARCH
DERMATOLOGY & SURGERY

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## AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

To: Lake Loveland Dermatology, Medical Records Request

Patient Name: _____

Date of Birth: _____

Phone: _____

I authorize and request the disclosure of all protected information to Monarch Dermatology & Surgery. I am transferring my dermatologic care to Monarch Dermatology & Surgery.

Please send all medical records to Monarch Dermatology & Surgery, meaning every page in my record, including but not limited to: Progress notes, face sheets, consultation notes, laboratory results, pathology results, test results, prescriptions sent, questionnaires/histories, correspondence, photographs, telephone communications, email communications and records received by other medical providers.

I authorize the physicians at Monarch Dermatology & Surgery to have access to my complete medical records to continue providing medical care.

Please send records to:

(Please Select)

**Monarch Dermatology & Surgery**

**Fax:** (720) 927-4301

**Mail:** 1615 Foxtrail Drive, Suite 100, Loveland CO 80538

**I hereby authorize Monarch Dermatology & Surgery to use and disclose Protected Health Information (PHI) as described above. I certify that I have read, signed and can receive a copy of this authorization upon my request.**

This Authorization is valid for one year from the date of signature unless otherwise indicated:
Date: _____

**Patient Rights:** I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form to have my previous medical records sent to Monarch Dermatology & Surgery in the manner specified. To receive health care when the purpose is to create health information for a third party. I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above-named practices based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are: 1) Fill out a revocation form (available from our office), 2) written communication to the office. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____

**Signature of Patient:** **Date:**

_____ _____

**Printed Patient Name:** **Relationship:**
(self / parent / legal guardian / personal representative)