

Kallgren Dermatology Clinic
3434 47th St. Suite 200 Boulder, CO 80301
Phone 303-444-8100 Fax 303-444-8113
Email kallgrenderm@comcast.net

Authorization for Release of Medical Records

Patient Information: (PLEASE PRINT)

Name: _____ Date of Birth: mm/ dd/ yy_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Please release my medical records FROM / TO (circle one):

Clinic Name: _____

Telephone Number: _____

Fax Number: _____

TO / FROM:

Kallgren Dermatology Clinic
3434 47th St. Suite 200
Boulder, CO 80301

Please send medical records no later than: _____
mm / dd / yy

Please release a copy of all my medical records, including but not limited to, medical notes, operative notes, laboratory results and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MY MEDICAL RECORDS

Patient Signature (parent if minor): _____ Date: _____
mm / dd / yy