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

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