Kallgren Dermatology Clinic
3434 47th St. Suite 200
Boulder, CO 80301
phone 303-444-8100 fax 303-444-8113
kallgrenderm@comcast.net www.kallgrenderm.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION: (**PLEASE PRINT)**

Name: _____Date of Birth:_____

Social Security Number: _____

Address:_____

City: _____State:_____Zip Code:_____

Phone Number: _____

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

Clinic Name:_____

Tel: Number: _____

Fax Number: _____

TO / FROM:

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

Please send medical records no later than: _____

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

BY MY SIGNATURE I AUTHORIZE RELEASE OF MY MEDICAL RECORDS

Patient Signature (parent if minor):_____Date:_____