Castle Rock Dermatology

755 Maleta Lane Suite 201, Castle Rock, CO 80108

Authorization for Release of Medical Information

Patient's Name: ___________________________D.O.B_____________SS#________________

I hereby authorize :

Name____________________________________Address________________________________

City______________________________________ST___________________Zip______________

To disclose information from my/my minor's child medical records to:

Castle Rock Dermatology, PC ~ Dr. Amy Broomer, D.O.

755 Maleta Lane # 201, Castle Rock, CO 80108

Phone 303-688-6355 Fax 303-688-6876

I specifically authorize release of the following information:

___ Drug abuse if any ___ Alcohol abuse or alcoholism if any ___ Venereal disease if any

___ AIDS/HIV if any ___ Psychological/Psychiatric conditions if any ___ Abortion if any

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Release these records:

_____ All medical records

_____ Biopsy results only

_____ Blood work only

_____ Blood work only

_____ Other: ____

I understand that I may revoke this consent at any time, except where information has already been released. A copy of this authorization may be utilized with the same effectiveness as an original.

____ __________________________

Signature: (parent or legal guardian if applicable) Date
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