DERMATOLOGY • DERMATOPATHOLOGY • MOHS MICROGRAPHIC SURGERY • PLASTIC SURGERY & AESTHETICS

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize (office releasing medical information) ____________________phone:____________ to release the following information to Vanguard Skin Specialists.

Patient Name:____________________________________ Date of Birth: _______________

Address: ____ Phone Number: ______________

City: ____State: ______ Zip: ____________

I authorize the release of the following protected health information:

☐ Office Notes
☐ Pathology Reports Date(s):________________
☐ Other:____
☐ Please omit the following from my records before sending:___________________________

The purpose for this request to release medical information is:

☐ Medical Care/Treatment ☐ Insurance ☐ Other (specify)___________________________

☐ Deliver my medical information to me by hand.

☐ Send my medical information to: Vanguard Skin Specialists
9348 Grand Cordera Pkwy., Ste 160
Colorado Springs, CO 80924
Fax: 719-623-2983

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation.
- Vanguard Medical Specialists, LLC may charge an administrative fee to cover the cost of labor, copying, and postage. The physician's office will inform me of any charges and arrange for payment.
- This authorization expires on ____/____/____ [if date not completed, one year after signed].

_________________________________ _____________________________

Signature of Patient / Representative Date

If the patient listed above is a minor or is unable to sign, and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_________________________________ _______________________

Signature of Patient / Representative Relationship to patient

BRIARGATE • BROADMOOR • CAÑON CITY • PUEBLO • WOODLAND PARK

9348 Grand Cordera Pkwy, Ste 160 • Colorado Springs, CO 80924
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