CASTLE ROCK DERMATOLOGY, PC

Amy Broomer, DO

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM CASTLE ROCK DERMATOLOGY

Patient's Name: ____D.O.B_____________

I hereby authorize Castle Rock Dermatology disclose information from my/my minor's child medical record to :

Name____________________________________Address________________________________

City______________________________________ST___________________Zip______________

Phone___________________________________ Fax____________________________________

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:

_____ Biopsy results only

_____ All medical records

_____ 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

CASTLE ROCK DERMATOLOGY
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www.castlerockdermatology.com
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