CASTLE ROCK DERMATOLOGY, PC

Amy Broomer, DO

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO CASTLE ROCK DERMATOLOGY

Patient's Name: ____D.O.B_____________

I hereby authorize:

Name____________________________________Address________________________________

City______________________________________ST___________________Zip______________

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

_____ 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
755 MALETA LANE, SUITE 201
CASTLE ROCK, CO 80108
PHONE:(303) 688-6355   FAX: (303) 688-6876
www.castlerockdermatology.com
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