Hill Center for Dermatology, PC
17560 S. Golden Rd., Suite 100
Golden, CO 80401
303-526-1117
303-278-0611 (fax)

MEDICAL RECORD RELEASE

To: ____
(Doctor or Hospital)

____
(Address)

I hereby authorize and request you to release my medical record to:

Hill Center for Dermatology, PC
17560 S. Golden Rd., Suite 100
Golden, CO 80401 (303) 278-0611 fax

Printed Name:____

Date of Birth:____

Signature:____

Signature of patient or guardian if patient is a minor:

____

Witness:____

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