

Kallgren Dermatology Clinic, P.C.
3434 47th Street, Suite #200
Boulder, CO 80301
303-444-8100
Email: kallgrenderm@comcast.net
Web Site: kallgrenderm.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION: (Please Print)

Name: _____ Date of Birth: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Please release my medical records from:

Clinic Name: _____

Tel. Number: _____

Fax Number: _____

TO

Kallgren Dermatology Clinic, P.C.
3434 47th Street, Suite #200
Boulder, CO 80301
303-444-8100
Email: kallgrenderm@comcast.net
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Please send Medical Records no later than: _____

Please release a copy of all my medical records, including but not limited to progress notes, operative notes, laboratory results, and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MY MEDICAL RECORDS:

Patient Signature: _____ Date: _____

If you are a former patient of Dr. Kallgren's please complete this form and fax it to Boulder Dermatology Clinic at 303-447-0794 Attn: Medical Records Department