



# MOUNTAIN STATE DERMATOLOGY



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## Release of Medical Records

To Whom It May Concern:

Please release a copy of the following (please check all that apply):

( ) Office / Treatment Notes ( ) Out-patient Labs / X-ray / Pathology Reports

( ) Other as Specified: \_\_\_\_\_

Date Range: From: \_\_\_\_\_ To: \_\_\_\_\_

Request Purpose: ( ) Medical ( ) Insurance ( ) Personal ( ) Legal ( ) Other

PATIENT: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY#: \_\_\_\_\_ PHONE#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

RECORDS SENT FROM:

RECORDS SENT TO:

\_\_\_\_\_

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PHONE#: \_\_\_\_\_

PHONE#: \_\_\_\_\_

FAX#: \_\_\_\_\_

FAX#: \_\_\_\_\_

**Attention:** By signing below you are giving consent for the release of your medical records. These records may be sent by ground transport or electronically via computer or fax machine. If they are received by another party in error you absolve Mountain State Dermatology of any and all liability relating to such transmission of your records. This consent is valid for six months from the date of your signature. You may revoke this consent by submitting such request in writing prior to the date your records are released. If you have any questions please ask any member of our staff. Thank you.

\_\_\_\_\_  
Signature of Patient / Patient Representative      Date

\_\_\_\_\_  
Witness      Date