Mountain State Medical Specialties, Inc.



Mountain State Dermatology Mountain Air Allergy & Asthma Mohs Micrographic Skin Cancer Surgery Center

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Please release a copy of t	70 Pg FP - TUNEST - TO STORE - TO	
() ALLERGY DEPT RECOR() DERMATOLOGY DEPT		
() Office / Treatment No		
() Out-patient Labs/X-Ro		
() Other:		
Date Range:		
From:	To:	
Request Purpose:		
() Medical () Insuran	ice () Personal	
() Legal () Other_		
Patient:		
Date Of Birth: So		
Phone#		
Address:		
Records Sent From:	Records Sent To:	
Ph#:	Ph#:	
Fax#:	Fax#:	
	Notice: Once w	
Signature of Patient/Patient Represe	ntative Date ceive your signer request, it may to one week release your rec	

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 staft. Thank you.

HIV-BEHAVIORAL HEALTH-DRUG ALCOHOL-PREGNANCY information contained within the records indicated above will be released through this authorization unless otherwise indicated below:

DO NOT RELEASE:

HIV
Sexually Transmitted Disease
Pregnancy Test
Behavioral Health/Psychiatric

Substance Abuse (which includes Alcohol/Drug Abuse)

(please list)