

**-DOCTORS-
SAWADA & SCHOLZ**

Specializing in Medical, Cosmetic and Laser Dermatology

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303-463-9600

DATE: _____ **PATIENT'S NAME:** _____
DATE OF BIRTH: _____

CONSENT TO RELEASE MEDICAL INFORMATION

I, _____, authorize Accent Dermatology and Laser Institute, PLLC, to release information regarding my medical condition, including any and all biopsy results, laboratory results or any other information requested to _____. Relationship: _____
(family member or other person)

This authorization applies only to the following date(s) of service: _____
_____ **Initial**

This authorization applies to the release of medical information from
this date forward until rescinded: _____
(date) _____ **Initial**

Patient: _____ Date: _____

Witness: _____ Date: _____