

INNOVATIVE DERMATOLOGY

5140 N. California Ave. Suite #660

Chicago, IL 60625-3642

P. 773-907-8454 F. 773-907-6336

Release of Information Authorization

Please print all information, then sign and date form below.

Type of Authorization: Release of protected health information to a designated person/entity.

Patient Name: _____ Date of Birth: _____

Maiden Name, if applicable: _____

Address: _____ City: _____ State: _____ Zip: _____

Purpose of Request – I authorize _____ to disclose or provide protected health information to: (Please identify individual or entity and address of those who will receive the information) _____

A. _____ all medical records in your possession, which includes those relating to **physical, social or psychological** health and well being: **Alcohol, Drug Treatment, and HIV results.**

B. _____ Medical record concerning treatment received from _____ through _____. (Insert dates)

Purpose of disclosure – (Please list)

I understand that if medical records are released, there will be an administrative charge, which is allowed by Illinois Law SB721. I understand I may refuse to sign or refuse to agree with this release, but in doing so I will not have access to the records.

Expirations or termination of authorization – This authorization will expire upon completion of this transaction. You have the right to terminate this authorization at any time. This request will be honored except to the extent of any action already taken of this authorization prior to revocation.

Right to revoke or terminate – As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our office. This request may be completed in the office or by mailing or faxing this form to the numbers listed above.

Regarding the disclosure – We have no control over the person(s) you have listed to receive the protected health information. Therefore, the protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of **Innovative Dermatology.**

Patient/Guardian Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____