5301 Keystone Court, Rolling Meadows, IL 60008
Phone: (847) 392-5440 Fax: (847) 385-0294

Authorization Form for Release of Confidential Health Information

Patient Name:_____ DOB: _____

I hereby authorize **Arlington Dermatology** use or disclosure of protected health information about me as described below:

_____ _____ _____
(Name of Health Care Facility, Physician, Agency, etc.) *(Phone Number)* *(Fax Number)*

_____
(Street Address, City, State and Zip Code)

☐ *Records release TO specified Physician or Healthcare Facility mentioned above FROM Arlington Dermatology*
☐ *Records release FROM specified Physician or Healthcare Facility mentioned above TO Arlington Dermatology*

☐ The entire medical record, unless, the following items have been specifically checked:
☐ Progress notes
☐ Laboratory reports
☐ Pathology Reports
☐ Photographs
☐ Other: _____

The above information for the following period of time shall be released: From:_____ to _____
(Date) *(Date)*

The purpose(s) of the authorization is (are) _____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.

I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires (30 days from date of request), unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician office.

Patient/Guardian/Representative Signature:_____ Date: _____

If you are not the patient, please specify your relationship to the patient: _____

Office Use Only

Request Date: _____
Date Sent: _____
Mail ($6.65) *Fax* *Pick-up* *Secure email*
Payment: $ _____
MRN: _____
Pages sent: _____
Completed by: _____