AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name ____ **Date of Birth**______________________

Phone Number_________________________

AUTHORIZES DISCLOSURE FROM:

Chicago Cosmetic Surgery and Dermatology
515 North State Street, Suite 900
Chicago, IL 60654

TO RELEASE MEDICAL INFORMATION TO:

____
Name of Health Provider/Organization/Individual

____
Street Address

____
City, State, Zip Code

INFORMATION TO BE DISCLOSED:

Date Range: ____________________to ______________________.

☐ Complete Medical Records ☐Lab Report(s) ☐ Biopsy Report(s) ☐ Consultation Report(s) ☐ Surgical Procedures(s)

☐ Other ____

I authorize release of information of the following portions of my medical record:

☐ Mental Health ☐ HIV/AIDS

☐ Substance Abuse ☐ Communicable Disease

☐ All ☐ Only the following: ____

Send records via: **Standard USPS mail or** **Encrypted email. Email Address:** ______________________________

YOUR RIGHTS REGARDING THIS AUTHORZATION:
Right to inspect or receive a copy of the health information to be used or disclosed: I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed.
Right to receive a copy of this authorization: I understand that if I agree to sign this authorization, which I am not required to do, I may request a signed copy of the form.
Right to refuse to sign this authorization: I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, or eligibility for health care benefits on my decision to sign this authorization.
Right to withdraw this authorization: I understand that written notification is necessary to cancel this authorization.
Further Disclosure: I understand, that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies.
Fees: I understand that for records I may be charged a minimum fee of $5.00.

EXPIRATION DATE: This authorization is effective for one (1) year from the date signed, unless otherwise indicated. Date (Optional)__________________.

X______________________________________
Patient or Legal Representative Signature/Relationship

X__________________________________
Date of Signature

____
Preparer of Records

____
Date of Signature

____
Provider's Signature

____
Date of Signature

NOTICE: The State of Illinois requires our office to provide your records within 30 days of receiving your request.

However, our office will make every effort to fulfill your request as quickly as possible.