Authorization for Disclosure of Protected Health Information

This form authorizes release of medical records from:

Physician Name: ____
Address: ____
City/State/Zip____
Phone Number____
Fax Number____

To be sent to:

Chicago Cosmetic Surgery and Dermatology
515 North State Street, Suite 900
Chicago, IL 60654
P 312-245-9965 F 312-245-9964

From the records of:

____ _______________________
Name of Patient Date of Birth

Please send the following information:

Check all that apply:
_______All medical records
_______Operative Reports, applicable dates _____________
_______Lab Reports, applicable dates__________________
_______Pathology Reports, applicable dates_____________
_______Other (specify) ______________________________

The information contained herein is confidential and is being provided in response to a written authorization.

X____ X __________________________
Patient or Legal Guardian Signature Date