Schaumburg Dermatology

911 N Plum Grove Rd. Suite A
Schaumburg, IL 60173
Office: (847) 534-0700
Fax (847) 413-1818

www.schaumburgdermatology.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name ____
Last First MI

Address ____

City ______________________________ State _________________________ ZIP ____________________

Phone _(____)_________________(____)_________________ Birthdate _____/______/________
Home Work

MRN ______________________________

I request and authorize ___________________________________ to furnish TO:

Person/Institution: ____

Address ____

City ______________________________ State _________________________ ZIP _____________________

Purpose or need for data: ____

A copy of my records covering my treatment during the period from _______________ to ____________________

Nature of Information requested: ___Discharge summary ___ Progress Notes ____ History and Physical

___ X Ray ____ Lab ____ Surgical reports

___ Other ____

I understand that my records are protected under the Federal and State law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include: Diagnosis, Prognosis, and Treatment for physical and/or emotional illness, including treatment of alcohol or substance abuse for any admissions and HIV testing results and information.

I understand that I have the right to revoke this content at any time by my submitting a written and dated notice of revocation to Schaumburg Dermatology, SC., releasing this information. If not revoked, this authorization is valid for 6 months.

SIGNATURE: ______________________________________ **DATED**: ______________________________

I hereby authorize ____________________________________ to pick up copies of my medical record in the event of unforeseen circumstances.____

****NOTICE TO RECEIVING AGENCY/PERSON:** Under the provisions of the Illinois Mental Health and Development Disabilities Confidentiality Act, you may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure. This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.