ILLINOIS DERMATOLOGY INSTITUTE

Authorization for Release of Confidential Health Information

Patient Name: ____________________________________ Telephone: __________________________________
Address: ____ Date of birth: ________________________________
City/State/Zip: ____________________________________ MRN (Office Use): _____________________________

*I authorize Illinois Dermatology Institute, LLC to **RELEASE** my protected health information to:*

Physician/Clinic Name: ______________________________________
Address: ____
Telephone: _____________________________________ Fax : _____________________________________

I authorize the release of information pertaining to the following time periods:
From date(s): __________________ To date(s): __________________

The following types of information to be disclosed are:

- ☐ **All Medical Records**
- ☐ Diagnostic Reports (labs, pathology, x-rays, etc.)
- ☐ Abstract (documents summarizing medical records)
- ☐ Billing Records
- ☐ Other: ____
  ____

The purpose(s) of this authorization is (are): ____

The following highly CONFIDENTIAL items must be checked off to be included in the disclosure:

- ☐ HIV/AIDS related health information/records (410 ILCS 305/9)
- ☐ Behavioral or mental health information/records (740 ILCS 10/1 et seq)
- ☐ Drug/Alcohol diagnosis, treatment, referral information (20 ILCS 201/20.5; 42 CFR, Pt. 2)
- ☐ Genetic testing information/records (410 ILCS 513/30)

**Signature of a witness who has verified the patient/personal representative's identity is required for mental health/developmental disability, genetic testing, HIV and drug/alcohol records. Additionally, signature of a patient is required for mental health records if patient is over the age of 12 and under the age of 18.*

____________________________	____________________________	____________________________
Witness Signature	Print Witness Name	Date

I authorize Illinois Dermatology Institute, LLC to use, disclose or obtain the requested health information during the term of this authorization. Unless otherwise noted, this authorization will expire sixty (60) days after the date of signature.
I understand that I may revoke this authorization in writing at any time by notifying the office. The revocation will not apply to the extent that any Illinois Dermatology Institute, LLC has already taken action where it relied on my permission. I understand that I have the right to inspect or copy any information used/disclosed under this authorization. I understand that once my health information is disclosed to the recipient, Illinois Dermatology Institute, LLC cannot guarantee that the recipient will not redisclose the health information to a third party or as required by law. The third party may not be required to comply with this authorization or privacy laws.
I have read and understand this authorization and have had a chance to ask questions about the disclosure of health information. I authorize Illinois Dermatology Institute, LLC to use/disclose/request my health information in the manner described above.

____________________________	____________________________	____________________________
Signature of patient or representative	Printed Name	Date