ILLINOIS DERMATOLOGY INSTITUTE
Excellence and Compassion

ILLINOIS DERMATOLOGY INSTITUTE, L.L.C.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

Dr. David Lorber **Dr. Nona Craig**

Dr. Jennifer Croix **Dr. Evan Stokar** **Dr. Sara Dickie**

Erin Melley, PA-C **Jamie Landau, PA-C**

Patient Name:_____Telephone:_____
Street Address:_____City:_____State_____Zip_____
Date of Birth:_____MRN# (office only)_____

I hereby authorize the disclosure of protected health information regarding the above-name person to:
Person/Institution/Other:_____
Address:_____
City:_____State:_____Zip:_____Phone:_____

yes	no	History and physical exam
yes	no	Consultation reports
yes	no	Progress Notes
yes	no	Operative Notes
yes	no	Abstract (documents summarizing history)
yes	no	Diagnostic reports (labs, x-rays, etc)
yes	no	X-ray films
yes		Other_____

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

yes	HIV/AIDS related health information/record
yes	Behavior or mental health information
yes	Drug/alcohol diagnosis, treatment, referral information
yes	Genetic testing information/records

The purpose of this authorization is (are)_____

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

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the privacy officer for the practice. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____

If I fail to specify an expiration date, event or condition, this authorization will expire in **sixty days**.

I understand that authorizing the disclosure of this health information is voluntary.
I (print name here) _____refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

If I have questions about disclosure of my health information, I can contact: Megan Novy, at **847-675-9711**, Privacy Officer of Illinois Dermatology Institute LLC.

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's office.

I have read and understood the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I knowingly and voluntarily authorize Illinois Dermatology Institute, LLC to use or disclose my health information in the manner described above.

Printed name of patient, legal representative, or authorized agent:

_____

Signature of patient, legal representative, or authorized agent:

_____

Date:_____**Relationship to patient:**_____

Witness:_____

Date:_____

Staff signature:_____
(to verify signer's identity)