NORTHSHORE DERMATOLOGY CENTER, S.C.
MEDICAL RECORDS RELEASE FORM

Authorization to Disclose Protected Health Information Date: _____

Patient: _____ DOB: _____

Address: _____ Phone: _____

( ) I authorize Northshore Dermatology Center to RELEASE INFORMATION TO:

_____

_____

_____

PHONE#_____

FAX#_____

( ) I authorize Northshore Dermatology Center to OBTAIN INFORMATION FROM:

_____

_____

_____

PHONE#_____

FAX#_____

The information to be disclosed (if such records exist):

____Billing Statement(s) ____Cosmetic Record(s)
____Clinical Records (s) ____Pathology Reports(s)
____Laboratory Report(s) ____Other: _____

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

THIS INFORMATION MAY BE DISCLOSED AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION:

Organization/Person: Northshore Dermatology Center

Organization Address: 925 Sherwood Drive, Lake Bluff, Illinois 60044

Fax: 847-234-1875 Email address: info@northshoredermatologycenter.com

This authorization DOES NOT apply to records related to HIV/AIDS, mental health, genetic testing, or drug/alcohol diagnosis. A separate, signed authorization form is required for those records. I understand that I may revoke my authorization at any time by making such a request in writing to Northshore Dermatology Center. This authorization shall expire automatically one year from the date of my signature, unless requested to end at an earlier date: _____. I also understand that once released, my protected health information may be subject to redisclosure.

I have read the above foregoing Medical Records Release and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient/Parent/Guardian Signature: _____ Date: _____
Parent/Guardian signature required for minor (less than 18 years of age)

Relationship to Patient (if other than self): _____
Printed name of Authorized Representative: _____