Medical Dermatology Associates of Chicago

Authorization for Use and Disclosure of Protected Health Information

I hereby authorize Medical Dermatology Associates of Chicago, Ltd. (MDAC) to use and/or disclose my protected health information as follows:

Dates of Disclosure: _____ to _____.

Information to be released:

- ☐ CHART NOTES.
- ☐ Referral/patient request/other: _____.
- ☐ LABS.
- ☐ PATHOLOGY REPORT.
- ☐ Other: _____ (please describe).
- ☐ All records generated by Medical Dermatology Associates.

Purposes for Release of Information:

- ☐ Release to another physician or health care institution (identified below).
- ☐ Information requested by Insurance Carrier.
- ☐ Continued Patient Care.
- ☐ For Patient's own records.
- ☐ Insurance Claim/Application.
- ☐ Other:_____ (please describe).

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.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed to and used by MDAC and any provider/facility identified below. I have the right to request a copy of this Authorization. I may revoke this authorization at any time by notifying MDAC in the manner set forth in the Notice of Privacy Practices. I understand that revocation will not apply to information that has already been released in response to this authorization. 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 1 year from the date signed.

I have signed this Authorization for the Use and Disclosure of Protected Health Information and hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

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_____ _____

Signature of Patient / Parent / Authorized Representative Date

_____ _____

Patient Name Date of Birth

_____ _____

Patient Phone (home) (work)

_____

Patient Address City/State/Zip

_____

Printed Name of Authorized Representative and Relationship to Patient

_____

Address and Phone Number of Authorized Representative

Above listed patient authorizes the following healthcare facility to receive the record:

_____

Provider or Facility Name

_____

Provider or Facility Address City/State/Zip

_____ _____

Provider or Facility Phone Fax

Please note: A copy fee of $35 may be charged for the medical records.

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