SCHAUMBURG DERMATOLOGY 911 North Plum Grove Rd. Suite A Schaumburg, IL 60173 O : 847-534-0700 F: 847-413-1818	**AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL RECORDS**	**CLINIC USE ONLY** ○ **Records sent from SD clinic – please image form to IMS chart** Mailed ___Picked Up ____Faxed ____ Date Received_____ Date Processed_____ Date and type of records rendered _____ _____ _____ _____ ○ **Forwarding Request for ROI to be processed**

Patient Name: _____Maiden/AKA: _____Date of Birth: _____

Street Address: _____MRN (optional)_____

City/State/Zip: _____Telephone: _____

1. ____ Myself: I request Schaumburg Dermatology to release my protected health information to **myself**.

Select delivery method: _____US mail _____Pick up from SD clinic ____Fax #: _____

2. ____ Other: I am the patient, or the legally authorized representative of the patient listed above and request _____ to **Release or Receive** my protected health information to: (Please circle applicable choices that are in (**BOLD**).

Individual/Person_____ Company/Organization: _____

Street Address: _____

City/State/Zip: _____Telephone: _____Fax: _____

Select delivery method: US Mail ____ Picked Up ____ Fax ____ Fax #: _____

3. Purpose of release/disclosure to other person/organization: (please indicate reason for disclosure below)

○ Continuation of Care/Transfer of Care	○ Insurance Company	○ Billing
○ Attorney/Legal	○ Workers Comp	○ Oher

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 bylaw. 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.