2560 Foxfield Rd Suite 100 St. Charles, IL 60174 P: 630-443-8855 F:630-443-8866
2128 Midlands Ct. Unit 106 Sycamore, IL 60178 P: 630-443-8855 F:630-443-8866
1050 W. Chicago Ave. Oak Park, IL 60302 P: 708-383-6366 F: 708-383-6449

Patient Authorization to Disclose Health Information

I authorize Clear Skin Dermatology to use or disclose the following information from my health records.

_____ The entire medical record
_____ Other: Please specify_____

The information described above will be disclosed to:

Name:_____
Address:_____
City:_____State:_____Zip:_____
Phone:_____Fax:_____

The information described above will be disclosed from:

Facility/Name:_____
Address:_____
City:_____State:_____Zip:_____
Phone:_____Fax:_____
My Authorization for disclosure of the information above expires on:_____

**I understand that if the person or entity receiving my health information is not a health care provider or a health plan covered by federal privacy laws, my health information to be disclosed as described above, may no longer be protected by these laws and may be re-disclosed.*
**I understand that I may refuse to sign this authorization form and that my refusal to sign this form will not affect my ability to obtain treatment or payment or my eligibility for benefits. If the protected health information requested is to be used or disclosed for determining my eligibility for a health plan refusal, my refusal to sign this authorization form may result in a denial of my application for benefits under the health plan.*
**I understand that I have the right to inspect or copy any of the information disclosed by the authorization.*
**I understand that I have the right to revoke this authorization at any time, in writing, except to the extent that Clear Skin Dermatology has already acted in reliance upon this authorization as shown by my signature below and as explained in the Notice of Privacy Practices.*
**I understand that Clear Skin Dermatology and its employees are released for any legal responsibility or liability for disclosure of my protected health information as described above and as authorized by my signature below.*
**I understand that I may request a copy of the signed authorization form at the time of submission.*

_____
PATIENT NAME AND DATE OF BIRTH

_____
SIGNATURE DATE

_____
PRINT NAME AND RELATIONSHIP IF SIGNED BY SOMEONE OTHER THAN PATIENT

Clear Skin Dermatology
& COSMETIC SURGERY

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