Core Dermatology
Peoria Ambulatory Surgery Center
Harlan & Steinhoff Dermatology Group

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name (Print) _____ SS or Chart Number _____ Patient DOB ____/____/____

_____ I authorize _____ (practice/physician's name) to release/disclose my health information as described below.

Please identify the information to be released:

☐ Please release my entire record

-OR-

☐ Please release ***only*** the following information (check appropriate boxes and include other information where indicated):

- ☐ Pathology Results Date(s): _____
- ☐ Laboratory Results Date(s): _____
- ☐ Office Visit Notes Date(s): _____
- ☐ Other (please describe): _____

The identified information will be used for the following purpose:

- ☐ My personal records
- ☐ Sharing with other health care providers as needed
- ☐ Other (please describe): _____

Please initial each item below to indicate your understanding.

_____ 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.

_____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal or state privacy laws or regulations. [NOTICE TO RECEIVING AGENCY/PARTY: Redisclosure is subject to the Illinois Mental Health Developmental Disabilities Confidentiality Act and the Confidentiality of Alcohol and Drug Abuse Patient Records Section of the Public Health Service Act.]

_____ I understand I have the right to inspect or copy my protected health information as provided under federal and state law. My refusal to consent to the release of the above information will prevent the disclosure of the same.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand 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.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be used by or released to the following individual(s) or organization(s):

Contact Name: _____ Company: _____

Address: _____ City/St/Zip: _____

Phone: _____ Fax: _____

This authorization will expire on (insert date or event): _____
If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

_____ ____/____/____
Patient Signature (or Signature of Person Completing Form if Not Patient*) Date

*Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other: _____

_____ ____/____/____
Witness Signature Date

Distribution of copies: original to practice, copy to patient, copy to accompany information released Orig. 3/03 Rev. 01/24