DERMATOLOGY
& MOHS SURGERY INSTITUTE

General, Surgical, and Cosmetic Skin Care

Phone: (309) 451-3376
Fax: (309) 452-3376

Authorization for Release of Confidential Health Information

Individual Information:

_____ __ __/__ __/__ __ __ __ (__ __ __) __ __ __ -__ __ __ __
Name Date of Birth Phone #

_____ _____ _____ _____ _____
Street Address Suite / Apt. City State Zip

Information may be disclosed by:

_____
Name of organization or person releasing information

_____ _____ _____ _____ _____
Street Address Suite / Apt. City State Zip

(__ __ __) __ __ __ -__ __ __ __ (__ __ __) __ __ __ -__ __ __ __
Phone # Fax #

Information may be disclosed to:

_____
Name of organization or person to receive information

_____ _____ _____ _____ _____
Street Address Suite / Apt. City State Zip

(__ __ __) __ __ __ -__ __ __ __ (__ __ __) __ __ __ -__ __ __ __
Phone # Fax #

Information to be disclosed:

Choose only ONE option. Copy fees may apply.

- ☐ Information from the most recent 2 years of office visits
- ☐ All information from date: __ __/__ __/__ __ __ __ to date: __ __/__ __/ __ __ __ __
- ☐ Information regarding specific treatment, condition, or other (specify): _____

Why are you asking for this health information to be released?

Choose only ONE option. Copy fees may apply.

☐ Attorney ☐ Insurance ☐ Doctor ☐ Medical Leave ☐ Personal ☐ Other: _____

Authorization:

This authorization expires 60 days from the date signed or on the date or event indicated here:

_____

Information released may include any of the following: laboratory reports, x-ray reports, operative notes, and information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency, or mental/psychiatric illness. By my signature, I give my specific authorization to be released.

I understand I have the 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.

_____ _____ _____
Printed Name Signature Date Signed

Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Power of Attorney