GLAZER DERMATOLOGY

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PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

(PLEASE PRINT CLEARLY)

I/Legal Guardian of,_____ _____
Patient Name DOB

_____
Patient Address

I Authorize _____
Name of Physician, Practice, Facility, etc.

To provide_____
Name of Physician, Practice, Facility, Fax, Mailing Address, Email, etc.

_____
Name of Physician, Practice, Facility, Fax, Mailing Address, Email, etc.

_____ **All Records**
_____ **Doctor's Notes** (Date of: _____)
_____ **Blood Work** (Date of: _____)
_____ **Pathology Report** (Date of:_____)
_____ **Other** – Please describe:
_____

Purpose or need for the information requested:

Continued Care _____ Insurance_____ Legal _____ Transfer_____ Personal_____

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated and signed communication. This consent will remain in effect no more than ninety (90) days from the date I signed this consent. I also understand that my medical records may include mental health information, drug/alcohol information and/or HIV information.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient an may no longer be protected by the federal HIPPA Privacy Rule.

I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

_____ _____
Patient/Parent/Legal Guardian Signature Date

_____ _____
Witness Signature Date

If signed by anyone other than the patient, please state relationship and reason for patient's inability to sign.

_____

A copy of this authorization has been _____ accepted _____ rejected by the patient/representative.

A photocopy or facsimile of this authorization will be considered valid unless otherwise specified.
Please note -- It can take up to 30 days to process your request

Fees and/or charges will comply with all Illinois laws and regulations applicable to the release of protected health information
Handling Charge = $33.60. First 25 pages = $1.26/pg. Pages 26-50, $0.84/pg. Pages in excess of 50, $0.42/pg.
Illinois 735 ILCS 5/8-2001(d) and (h); Updated May 2023

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