AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

The Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), which became effective April 14, 2003, requires that all of the following elements must be completed for an authorization to be valid.

Patient Name _____

Address _____

City, State, & Zip Code _____

Phone Number _____

Date of Birth _____

I hereby authorize that the protected health information regarding the above-named person be forwarded:

From: **JOHNSON DERMATOLOGY**
3310 W. Main St., Suite 115
St. Charles, IL 60175
Telephone (630) 232-2885
Fax (630) 232-9936

To: Person/Organization _____

Address _____

City, State, & Zip Code _____

Purpose or Need for Information: _____

Disclosure will include (check all that apply):

_____Operative Report _____Discharge Summary _____ Laboratory Reports

_____ X-Ray/Radiology Report _____Pathology Reports _____Progress/Physician Notes

_____ Consultation Report _____Other: _____

Records for the period (dates) from _____to_____

Do **not** release information related to alcohol and/or drug abuse, HIV/AIDS testing and/or treatment, psychiatric and psychological records unless specified above.

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent the action has already been taken to release this information. This Authorization shall remain valid unless revoked but **will expire in one year after signing.** I have a right to inspect a copy of the health information to be released, and if I do not sign this Authorization, the organization named above will not release my health information. The above named person/organization will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

_____ _____
Signature of Patient **Date**

_____ _____
Signature of Parent/Legal Guardian/Personal Representative **Relationship to Patient**

_____ **Requested:** ☐
Witness