4948 Benchmark Centre Drive
Swansea, Illinois 62226
Phone: (618) 628-2588 Fax: (618) 628-1363

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1) PATIENT INFORMATION:

_____

Name Address City State Zip

_____

Date of Birth Contact Number Previous Name(s)

2) AUTHORIZES:

_____

Name of Health Care Provider/Plan/Other

_____

Address Fax # of Health Care Provider

3) TO DISCLOSE TO: ☐ Self, Delivery Options: ☐ Pick up ☐ Mail to address above

☐ E-mail to: _____

If the e-mail is shared with another person or the e-mail password if known to other, consider other methods of deliver. Musick Dermatology & Advanced Clinical Spa, LLC will automatically send e-mail through encrypted/secured means unless otherwise directed. Unencrypted email poses some level of risk, e.g., a third party could see the information without consent. Musick Dermatology & Advanced Clinical Spa, LLC is not responsible for unauthorized access to unencrypted email containing confidential information or any risk (e.g., a virus) potentially introduced to the computer/device utilized when receiving/viewing confidential information in an unencrypted electronic format or email. By selecting the encrypted email option, I acknowledge the risks have been communicated and I accept these risks.

☐ To be picked up by, I authorize _____ to pick up my records. (Photo ID required)

☐ **Send To:** _____

_____

4) DATE(S) OF INFORMATION TO BE DISCLOSED: From _____ to _____
(month/year) (month/year)

5) INFORMATION TO BE DISCLOSED:

☐ Complete medical records ☐ Pathology/Surgical Reports ☐ Billing Records
☐ Lab reports ☐ Office notes ☐ Other: _____

6) EXPIRATION: This authorization is will expire one (1) year from the day requested.

7) PURPOSE: Please select a reason for the request (check all that apply – copy fees may apply): Patient Request

☐ Continuing Care ☐ Legal Investigation/Action ☐ Insurance Eligibility/Benefits ☐ Other: _____

***8)* YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I understand that I have the following rights:** to inspect and/or receive a copy of health information; to have information be used and/or disclosed by this Authorization; if I agree to sign this authorization, I will be provided with a copy of it; I may be charged a fee for record copies; I am under no obligation to sign this form and treatment, payment, enrollment or eligibility for benefits may not be based upon my decision to sign this Authorization; Authorization may be needed to release information to payers for certain mental health services, however, I can refuse to sign this Authorization form for such purposes but I may be responsible for paying entire bill for such services; I may revoke this Authorization at any time by notifying the authorizing provider's health information department, as listed above, in writing, and will not be effective as uses and/or discloses disclosures already made in reliance upon Authorization, needed for insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage, or to submit a claim to third party payers as provided in this Authorization may be subjected to re-disclosure by the recipient and may no longer be protected by applicable federal privacy law or Illinois Law. *Federal Regulation (42 CRF, Part 2)/AODA prohibits any further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted y regulations. However, I understand that any disclosure of information carries the potential for unauthorized re-disclosure and the information may not be protected by Federal privacy standards. I understand that if there is not an existing treatment provider relationship with the party to whom information is being sent, a general designation may be used. I understand that I may request a list of entities to which my information has been disclosed from the "Send To" entity listed above.*

9) SIGNATURE OF PATIENT: _____ DATE: _____ and/or

SIGNATURE OF LEGAL REPRESENTATION: _____ DATE: _____

If requested and signed by a person other than the patient, complete the following:

1) Patient is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased

2) Legal Representative: ☐ parent ☐ legal guardian ☐ next of kin/executor of deceased