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

Patient Authorization for Release of Medical Information

This form allows Musick Dermatology, LLC & Advanced Clinical Spa to send records on your behalf

Patient Information:

Name: _____ Date of Birth: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Information Request

I hereby authorize Musick Dermatology, LLC. & Advanced Clinical Spa, its affiliates, medical staff, employees, and their representatives to release my protected health information in the manner listed below and to the following:

Send By: (Choose ONE): ☐ Fax ☐ Secure Email: _____ ☐ Pick Up ☐ Mail

Send To: (if pick up, disregard):

Name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip: _____

Please Send:

☐ All Records (Notes, Labs, Pathology Reports, etc.) *Date from*: _____ *Date to:* _____

OR

☐ Specific Item(s) Only: (please list): _____

** Depending on your request, it can take 1-2 weeks to receive records, though most requests are fulfilled sooner**

Purpose of Release (check all that apply – copy fees may apply)

☐ Continuing Care with whom: _____ ☐ Legal Investigation/Action

☐ Insurance Eligibility/Benefits ☐ Other: _____

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.*

Signature: _____ Date: _____ AND/OR

Signature of Legal Representation: _____ Date: _____ Relationship: _____