1331 w. 75TH Street, Unit 402, Naperville, IL 60540
P: 630.596.8045 **F:** 630.590.9634

HIPAA AUTHORIZATION FORM

Authorization To Release Medical Information

PATIENT'S NAME:___________________DOB: _______________MEDICAL RECORD #:________________

I hereby authorize Basko Dermatology to release my medical information to the provider, person, facility below:

Name of Provider, Person, Facility: ____

Address: ____

Phone:___________________________________Fax: _____________________________________

Dates of Disclosure: ________________________ To ______________________________________

Information to be released (send copies or discuss over the phone):

□ Exam Notes
□ Laboratory results
□ Pathology report
□ Complete medical record
□ Other (please describe):

Authorization To Leave Voicemail With Pertinent Medical Information

PATIENT'S NAME:___________________DOB: _______________MEDICAL RECORD #:________________

I hereby authorize Basko Dermatology to leave a voicemail message with my medical information

Patient/Parent/Authorized Representative Signature:____

Name of Authorized Representative and Relationship to Patient:___________________________________

Phone: ____________________________

Date: ____________________________

I may revoke this authorization at any time by notifying Basko Dermatology in the manner set forth in the Notice of Privacy Practices. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law. Unless otherwise revoked, this authorization will expire on____________.

Patient/Parent/Authorized Representative Signature:____

Name of Authorized Representative and Relationship to Patient:___________________________________

Date: ____________________________