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Office: (630) 596-8045
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HIPAA AUTHORIZATION FORM

Authorization to Release Medical Information

PATIENT'S NAME: ____ **DATE OF BIRTH:** ________________

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 reports □ Complete medical record

□ Other (please describe): ____

This protected health information is disclosed for the following purpose:

□ Continuity of care □ Transfer of care □ Moved out of area □ Change of insurance

□ Dissatisfaction: □ Provider □ Billing □ Staff

Please specify: ____

□ Other: ____

I understand the following: (per HIPAA law CFR §164.508(c)(2)(i-iii))

- I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization
- The information released in response to this authorization may be re-disclosed to other parties
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization

SIGNATURE: ____ **DATE:**__________________