MD SkinCenter

Dermatology • Mohs • Facial Plastic Surgery

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Patient number: _____

Address: _____

Telephone: _____ Date of birth: _____

I hereby authorize and request that the protected health information regarding the above-named individual be used or disclosed as follows during the term of this Authorization.

Release information from:

- ❑ MD SkinCenter
  1235 N. Mulford Road, Suite 205
  Rockford, IL 61107
  Tel: 815-484-9900
  Fax: 815487-4949
- ❑ Other (specify name and address of physician/facility below, including phone/fax if known)

Release information to:

- ❑ MD SkinCenter
  1235 N. Mulford Road, Suite 205
  Rockford, IL 61107
  Tel: 815-484-9900
  Fax: 815-487-4949
- ❑ Other (specify name and address of physician/facility below, including phone/fax if known)

Purpose or need for this disclosure:

- ❑ Personal use/at the request of the individual (there is a fee for personal use copies)
- ❑ Medical care / other health care providers (no charge if sent directly to the provider)
- ❑ Insurance purposes
- ❑ Other (please specify) _____

For the following treatment or time period (e.g. specific date 1/25/13; range Jan-July 2013; all dates of service)

From: To:

The type of information to be used or disclosed is as follows (check all that apply):

- ❑ Entire medical record
- ❑ Abstract of above only (includes dictated reports and diagnostic test results)
- ❑ Medical imaging films (X-rays, CT, MRI, CINE)
- ❑ Other (please specify) _____

Note: If this Authorization is for psychotherapy notes, no other type of protected health information may be requested on this Authorization and a witness signature will be required.

Specific consent:

I understand that I must check one or more of the following types of information that I do **not** want released to the recipient. I understand that if I do not check any of the following items, the information released to the recipient may include any of the following:

- ❑ Information about a mental illness or developmental disability (including psychiatric, psychological records or evaluation and/or treatment for mental and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans and/or evaluation)
- ❑ Information about HTL-V-III or HIV/AIDS testing, results, diagnosis or treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- ❑ Information about communicable diseases
- ❑ Information about venereal diseases
- ❑ Pregnancy
- ❑ Birth control
- ❑ Information about substance (alcohol and/or drug) abuse (including diagnosis, evaluation and/or treatment)
- ❑ Information about abuse of an adult with a disability
- ❑ Information about sexual assault/abuse
- ❑ Information about child abuse/neglect
- ❑ Information about genetic testing

Expiration:
This Authorization must be received within 90 days of the date of signature and **will expire one year from the date of signature** unless otherwise specified or revoked in writing.

Please read the following carefully:
I understand this Authorization is voluntary and made to confirm my decision to have my personal health information used and/or disclosed for a specific purpose. I have the right to inspect a copy of the information to be released. I confirm that no person has coerced or imposed any inappropriate conditions on my providing this Authorization and I have had full opportunity to read and consider the contents of this Authorization and to ask questions about the use and/or disclosure of my health information.

I understand that this Authorization will expire one year from the date of signature unless otherwise indicated or revoked in writing earlier. I may change my mind and revoke this Authorization at any time. The revocation must be in writing and delivered to the provider/facility releasing the information. If the revocation is for MD SkinCenter, it must be delivered to *1235 N. Mulford Rd., Ste. 205, Rockford, IL 61107, Attn: Privacy Officer*. The revocation will not apply to any action that has already been taken in response to this Authorization and it will not apply to my insurance company when the law provides it the right to contest a claim under my policy.

I understand that, with certain exceptions, health care providers and others may not condition treatment, payment, enrollment or eligibility for benefits on obtaining an authorization. Exceptions may exist if the only purpose of treatment is to create health information to be disclosed to the recipient in this Authorization (such as for a pre-employment or pre-enrollment physical) or if my treatment is related to my participation in a research study or for health plan enrollment or eligibility. If I refuse to authorize release of information required to process insurance reimbursement, I may be financially responsible for the underlying services.

I understand the potential for further disclosure by recipients of the information to others who may not be subject to privacy or confidentiality protections. MD SkinCenter cannot guarantee that the recipient in this Authorization will not redisclose any or all of the information to others or as required by law. Notice is hereby given to the recipient that laws prohibit the redisclosure of any health information regarding drug and/or alcohol abuse, HIV/AIDS and mental health treatment unless specifically authorized by the person who authorized the disclosure.

I understand that my health information may be stored electronically on computers and in hard copy and can be accessed by physicians, medical support personnel and other health care providers at other facilities who are authorized to participate in my care. I understand that I am authorizing the information above to be released orally, through copies of medical records and/or by fax.

I hereby release and hold harmless MD SkinCenter, affiliated organizations, clinics and their respective staff, providers, directors, officers, employees, agents, successors, assigns and attorneys from and against any and all liability, damages, claims or suits, including reasonable attorney's fees, in connection with the disclosure or use of the information as identified in this Authorization.

I confirm that I understand the contents of this Authorization and that they are consistent with my direction to you. By signing this form, I knowingly and voluntarily confirm my authorization to use and/or disclose the information described in this form in the manner described in this form.

Signature of patient* (patients ages 12-17 may be required to sign and date with co-signature of parent/legal guardian)	Date
Co-signature of personal representative, if applicable**	Date
Name of personal representative, if applicable	Relationship to patient
Witness***	Date

*For information regarding mental health, HIV/AIDS, STDs, pregnancy, birth control, abortion, drug/alcohol abuse of patient or by family member, the **patient 12 or over must sign** to authorize the use or disclosure of these records. The personal representative's signature is not required and cannot be accepted without the patient's signature.

**The personal representative is the patient's decision maker and can be the parent of a minor patient, legal guardian, health care surrogate or other person.

***Witness signature required if this Authorization is for information about mental health/developmental disability information or records.