MD | MOORE DERMATOLOGY ASSOCIATES

AUTHORIZATION TO RELEASE INFORMATION

Name_____
(Last) (First) (Initial)

Address_____
(Street) (City) (State) (Zip)

Phone (_____)_____Date of Birth_____SS#_____

I authorize _____to release medical information from my medical record to be sent to:

Name_____

Address _____

City/State/Zip Code _____

Phone #_____Fax #_____

Email Address_____

Kindly note, by providing the email address and/or Fax number incurs no fee. However, if you request the medical records in paper form, there will be a minimum fee charged of $35.00.

I authorize you to release the following:

_____My entire record without limitations
_____My medical record except for information in regards to HIV/AIDS
_____My medical record except for information in regards to Mental Health
_____My medical record except for information in regards to Substance Abuse
_____My medical record from other physicians I have seen, that the doctor has in my file
_____My Pathology slide or block #_____

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Patient Signature (for patients age 18 or over) _____**Date** _____

Signature of Parent/Guardian/Legal Representative_____**Date**_____

FOR OFFICE USE ONLY

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Received_____**Sent**_____

Release consisted of _____

501 W. North Avenue, Suite 103
Melrose Park, IL 60160
708 450-5086 phone
708 345-4075 fax

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