



Diplomates of American Board of Dermatology
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Standard Authorization of use and Disclosure of Protected Health Information

Patient Information

Name _____ D.O.B. _____

Address _____

City, State, Zip _____

Please release Medical Records

To or From

**Deerfield Dermatology Associates, Ltd.
707 Lake Cook Road Suite 280
Deerfield, IL 60015
Phone : (847) 480-0004
Fax : (847) 480-8707**

To or From

Name _____

Address _____

City, State, zip _____

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Deerfield Dermatology Associates, Ltd. You should contact the office manager to terminate this authorization.

Potential for Rediscovery

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. the privacy of this information may not be protected under the federal privacy regulations.

Signature of patient or legal guardian

Date