Deerfield Dermatology Associates, Ltd.

Diplomates of American Board of Dermatology
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Medical Records Authorization and Release

Patient Information:

Name _____D.O.B. _____
Address _____
City, State, Zip_____

I request a copy or summary of the following medical records:

- ☐ Complete Medical Record
- ☐ Biopsy Report(s)
- ☐ Lab Report(s)
- ☐ Consultation Reports
- ☐ Medication Allergies
- ☐ Allergy Test/Treatment
- ☐ Surgical Procedures
- ☐ Other _____

Please check one:

- ☐ For dates of service from ___/___/_____ to ___/___/_____
- ☐ For all dates of service

Reason for request:

- ☐ Personal
- ☐ For Primary Care Physician
- ☐ Transfer to Another Dermatologist (*Please specify reason)*_____

As a courtesy, Deerfield Dermatology does not charge a copying fee if records are less than 15 pages. A reasonable copying fee, as permissible by state law, will be charged if records are more than 15 pages. 2015 charges are as follows: Handling charge: $26.58, p1-25 $1 per page, p26-50 66cents per page; pages over 50 33 cents per page; plus postage.

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 _____
Fax Number_____

Right toTerminate 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 Redisclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent.

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Signature of patient/Authorized Representative **Date**