CENTRAL ILLINOIS DERMATOLOGY, S.C.

5401 N. Knoxville Ave, Suite 115
Peoria, IL 61614-5095
Telephone (309) 691-2903
Fax (309) 691-2909

Christopher T. Kroodsma, M.D.
Jamie L. Frey, M.D.
Katherine Beaudry, M.D.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME ____ DOB: ___________________________

I authorize Dr./Office: ____
to release/disclose my health information as described below……………

PLEASE IDENTIFY THE INFORMATION TO BE RELEASED:

- ☐ Entire Record
- ☐ Pathology Results Date(s): __________________ to _________________
- ☐ Laboratory Results Date(s): __________________ to _________________
- ☐ Clinical Visit Notes Date(s): __________________ to _________________
- ☐ Other (please describe) ____

THE IDENTIFIED INFORMATION WILL BE USED FOR THE FOLLOWING PURPOSE:

- ☐ My personal records
- ☐ Sharing with other healthcare providers for continuation of care
- ☐ Other (please describe) ____

PLEASE INITIAL EACH ITEM BELOW TO INDICATE YOUR UNDERSTANDING:

_______When my information is used and disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

_______I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_______I understand I have the right to inspect or copy my protected health information as provided under federal and state laws. My refusal to consent to the release of the above information will prevent the disclosure of the same.

_______I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire on (date) _________________. If I fail to specify a date the authorization will expire in 90 days.

The identified information may be released to the following:

NAME /COMPANY _______________________________

ADDRESS ___________________________________

PHONE /FAX _____________________________ _____

AUTHORIZED SIGNATURE _______________________

PRINTED NAME _______________________________

DATE ____