ELK GROVE DERMATOLOGY, S.C.
EST 1986

Dr. Robert Polisky, M.D.

901 Biesterfield Rd. Suite 209 Elk Grove Village, IL 60007

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

Patient's Name: _____

Date of Birth:__ /___/_____

I request and authorize: _____

To release healthcare information to: _____

Name: _____ **Office Phone:** _____

Fax: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

This request and authorization applies to:

THIS SECTION MUST BE COMPLETED TO PROCESS YOUR REQUEST

For Dates of Service_____**To**_____**(Please Specify in MM/DD/YY)**

Copies of all medical records including the below:

☐**The entire medical record**
☐**Laboratory reports**
☐**Pathology reports**
☐**Operative notes**
☐**Other:** _____

ARE YOU TRANSFERRING? ☐**NO** ☐**YES** (if yes, please indicate reason below)
☐*Relocating* ☐*Insurance Change* ☐*Other*_____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law. I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to third party. I understand that information used or disclosed pursuant to this authorization is valid for 180 days from the date it was signed, unless revoked before that. I understand that I may revoke this authorization in cases where Symphony Medical Group has already relied on it to use or disclose my health information.

Signature of Patient or Legal Guardian Date

Last Name First Name

Relationship if not the patient: _____