

# AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

I, \_\_\_\_\_

(First) (Middle) (Last) (Maiden/Other name)

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY#: \_\_\_\_\_

PHONE#: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP CODE: \_\_\_\_\_

*If requesting records for your own file there is a FLAT FEE of \$30.00 (This includes paper(in office pick up), and/or faxing requests. An additional \$15.00 for Federal Express delivery.*

**in office pick up**

fill out the below mailing information. If faxing please include fax number.

Fax number \_\_\_\_\_

**Federal Express**      **Hereby authorize and request records to be sent to:**

**Records sent from:**

Advanced Dermatology & Mohs Surgery

Sharon L. Horton, M.D.

1049 E. Wilson St., Ste 190

Batavia, IL 60510

P#:(630)482-3700 F#:630-761-8724

**THE AUTHORIZATION APPLIES TO THE FOLLOWING INFORMATION:**

All records    Office notes    Laboratory    History/Physicals    HIV Results

Other (please specify) \_\_\_\_\_

Information in selected above may be released from date: \_\_\_\_\_ to \_\_\_\_\_

Are you leaving the practice?    Yes    No

**The purpose of this release is for:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Consult (second opinion)        | <input type="checkbox"/> Requested for Governmental Agency | <input type="checkbox"/> Attorney        |
| <input type="checkbox"/> Dissatisfied with practice      | (Dept.of Rehab, Social Security, etc.)                     | <input type="checkbox"/> Insurance Claim |
| <input type="checkbox"/> Dissatisfied with the Physician | <input type="checkbox"/> Relocating out of the area        |  |
| <input type="checkbox"/> Insurance underwriting          | <input type="checkbox"/> Change of Insurance               |  |

**Comments:**

Expiration Notice: I understand that this authorization shall expire, without express revocation, when processing of this request is completed.  
Revocation: This authorization will be considered valid for 60 days from the date signed. Revocation of this authority may be given at anytime via written notice to Advanced Dermatology and Mohs Surgery office. Any revocation will have no effect on disclosures made prior thereto.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship if other than patient–Parent/Legal Guardian