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Meyer A. Horn, MD
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1765 N. Elston Ave.
Suite 110
Chicago, Illinois 60642
T 773.276.1100 F 773.276.1102

Authorization for Release of Information

Records to be released from:

Dermatology + Aesthetics
1765 N. Elston Ave. Suite 110
Chicago, IL, 60642
P: 773.276.1100
F: 773.276.1102

Print Patient's Name_____

Address _____

Date of Birth_____/_____/_____ **Phone ( ) _____ - _____**

I_____hereby authorize **Dermatology + Aesthetics** to release (written/oral/electronic) information to:

Agent/Facility/Person_____

Address_____City/State/Zip_____

INFORMATION TO BE RELEASED

O Clinic/Office Records O Pathology Reports O Lab Reports O Slides

O Consultations O History O Other Diagnostic Tests O ALL RECORDS

O Other (Please Specify) _____

_____

This should include sensitive information such as mental, substance abuse, or HIV/AIDS **unless checked below**

O Mental Health O Substance Abuse O HIV/AIDS O Other_____

These records are obtained for the purpose of: O Continuity of Care O Other

I understand that I have the right to inspect the disclosed information and may revoke this authorization at any time in writing except that records have already been released. In the event that written revocation of this consent is not made, this authorization will automatically expire in (6) months unless expiration date is otherwise amended. There is a handling fee of $26.00, a copy fee of $.50 per page and any shipping fees if applicable. All fees for the transfer of records are the responsibility of the patient. Payment is required prior to releasing records. Records will be processed within 10 days of request.

_____

Signature Patient or Legally Authorized Patient Representative Date of Signature

_____

Signature of Witness Date of Signature

OFFICE USE ONLY Request Received By:_____ Date: _____
Records Processed By: _____Date: _____ For Pt pick up_____or Mail date_____
Handling $26.00 + # of pages _____x .50 =_____ plus shipping_____ Total $_____
Payment Processed By:_____ Date_____

Rev 08142015 cb