AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/ PROTECTED HEALTH INFORMATION

This document must be signed by the patient or person authorized by law.

Please complete and either fax to **312.266.6481** or email to our secure email at **submit@nimaskininstitute.com**

Name:_____Date of Birth _____

I, _____hereby authorize NIMA SKIN INSTITUTE to release my medical records to:

Name of Doctor/Medical Office: _____

Address: _____

_____

Phone number: _____

Fax number: _____

HIPAA Secure email: _____

DESCRIPTION OF HEALTH INFORMATION SUBJECT TO AUTHORIZATION

By placing a checkmark in the spaces below, I authorize the release of the following records pertaining to services from _____ _____ to _____ [insert dates]:

___ Complete medical record (all information)

___ Laboratory reports

___ Pathology reports

I understand that the health records and information disclosed, or some portion thereof, may be protected by the Federal Health Insurance Portability and Accountability Act ("HIPAA"). I further understand that it is possible that the information described on page 2 may be re-disclosed by the recipient and may no longer be protected by HIPAA (See *Redisclosure* statement). I further understand that my records may be protected under state law and, if so, cannot be disclosed without my written consent unless otherwise provided for in the law and/or regulations.

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

This Authorization for Release of Protected Health Information shall expire one (1) year from the date below.
My signature below acknowledges that I have read, understand, and authorize the release of the information.

_____ _____

PATIENT SIGNATURE: Date

_____ _____

LEGAL GUARDIAN/PERSONAL REPRESENTATIVE SIGNATURE: Date