Stees Dermatology S.C.

AUTHORIZATION TO OBTAIN HEALTHCARE INFORMATION

Patient's Name _____ Date of Birth: _____

Social Security #: _____ - ____ - _____

I request and authorize _____ to release healthcare information of the patient named above to:

Stees Dermatology S.C.
215 E. 1st St Ste 305
Dixon, IL 61021
Phone: (815) 285-5484
Fax: (815) 285-5486

This request and authorization applies to:

☐ Dermatologic conditions (dermatology clinic notes, pathology, labs)

☐ Healthcare information relating to the following treatment, condition, or specific date.

_____

_____

☐ All Healthcare information.

☐ Other: _____

Patient Authorization: I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drugs and /or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

EXCLUDE the following information from the records to be released (please initial as appropriate).

____ Drug/Alcohol abuse treatment/diagnosis ____ Sexually transmitted diseases
____ HIV/AIDS diagnosis/treatment/testing ____ Mental illness, psychiatric diagnosis

_____ _____
Signature of Patient, Guardian, or authorized representative Date

THIS AUTHORIZATION EXPIRES NINETY (90) DAYS AFTER IT IS SIGNED