# Stees Dermatology S.C.

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

## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name _____ Date of Birth: _____

Social Security #: _____ - ____ - _____

I request and authorize Stees Dermatology S.C. to release healthcare information of the patient named above to:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (  ) _____-_____ Fax: (  ) _____-_____

This request and authorization applies to:

☐ Dermatology related conditions, including clinic notes and pathology.

☐ 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