Authorization For Disclosure of Health Information

This form authorizes release of medical records from:

Physician Name: _____
Address: _____
City/State/Zip_____
Phone Number_____
Fax Number_____

To be sent to:

Chicago Cosmetic Surgery and Dermatology
20 West Kinzie Street, Suite 1130
Chicago, IL 60660
P 312-245-9965 F 312-245-9964

From the records of:

_____ _____
Name of Patient Date of Birth

Please send the following information:

Check all that apply:
_____All medical records
_____Operative Reports, applicable dates _____
_____Lab Reports, applicable dates_____
_____Pathology Reports, applicable dates_____
_____Other (specify) _____