HIPAA AUTHORIZATION FORM

Patient's Full Name	Patient's Medical Record Number	Patient's Date of Birth

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following person, medical provider, or organization may receive disclosure of protected health information about me.
   - ☐ Patient or Guardian: _____
   - ☐ Medical Provider: _____
   - ☐ Practice/Clinic/Hospital: _____
   - ☐ Other: _____
2. The purpose of this medical release is:
3. Select which delivery options are ok:
   - ☐ U.S. Postal Mail ($6.70): _____
   - ☐ Secure Email: _____
   - ☐ Fax: _____
   - ☐ Other: _____
4. The specific information that should be disclosed is (please give dates of service if possible):

   Date(s) of service requested: _____

☐ Clinical Note(s)	☐ Pathology Report(s)	☐ Photo(s)
☐ Laboratory Report(s)	☐ Pathology Slide(s)	☐ Billing

5. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
6. I may revoke this authorization by notifying **Derick Dermatology, ATTN: Authorization Revocation, 1531 S Grove Avenue, Unit 101, Barrington, IL 60010** in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
7. I understand that if this authorization is to release protected health information to the patient (myself) or guardian, this authorization is for this single request. In the case of release of protected health information to a medical provider, practice, clinic, hospital, or third party, this authorization does not expire until the patient revokes this authorization as described in item 6 above.
8. I understand that Derick Dermatology may not condition treatment on this authorization.

Signature of Individual, Guardian or Personal Representative of Patient's Estate (The person about whom the information relates)	**Date of Signature**

A copy of this completed, signed and dated form must be given to the Individual or other signatory.

Notice of Nondiscrimination

Derick Dermatology complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Derick Dermatology does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Derick Dermatology:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please contact Ashley Rady at 847-381-8899 x1113

If you believe that Derick Dermatology has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Ashley Rady, Civil Rights Coordinator in person, or via mail, fax or email at:

Derick Dermatology
Attn: Civil Rights Coordinator
1531 S. Grove Ave. Suite 101
Barrington, IL 60010

Phone: 847-381-8899 x1113
Fax: 847-381-8999
Email: CRC@derickdermatology.com

If you need help filing a grievance, Ashley Rady, our Civil Rights Coordinator, is available to assist you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Ave, SW
Room 509F, HHH Building
Washington D.C. 20201
Phone: 800-368-1019 / 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-847-381-8899.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-847-381-8899.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-847-381-8899.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-847-381-8899 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-847-381-8899.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 847-381-8899

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-847-381-8899.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-847-381-8899

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-847-381-8899

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-847-381-8899

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-847-381-8899

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-847-381-8899

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-847-381-8899

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-847-381-8899

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-847-381-8899

