NORTHWESTERN SKIN CANCER INSTITUTE, LTD

CONSENT FOR RELEASE OF INFORMATION

_____ _____/_____/_____

Patient's Name **Date of Birth**

Release **TO** NWSCI

RELEASE **TO** NORTHWESTERN SKIN CANCER INSTITUTE

I hereby authorize _____
Or his/her employees or agents to release the following information from the medical records of the patient named above the following:

___ Copy of Entire Record ___ Test Results ___Other: _____

I authorize this confidential information to be released to:

NORTHWESTERN SKIN CANCER INSTITUTE
737 North Michigan Ave, Suite 2310, Chicago, IL 60611
Phone: 312-266-6647 Fax: 312-266-6612

Release **FROM** NWSCI

RELEASE **FROM** NORTHWESTERN SKIN CANCER INSTITUTE

I hereby authorize Dr. JC Lapiere, Dr. Neda Ashourian, Danielle Sandoval or his/her employees or agents to release the following information from the medical records of the patient named above the following:

___ Copy of Entire Record ___ Test Results ___Other: _____

I authorize this confidential information to be released only to the following person, agency or organization:

Name: _____

Phone: _____ Fax:_____

THE PURPOSE OF THIS DISCLOSURE IS:

___ continued medical care ___ to process insurance claims ___ to complete insurance application
___ other:_____

This authorization to release confidential medical information may be revoked by me in writing at any time, except to the extent that action has already been taken in reliance on it. It will be effective only long enough to fulfill the specific purpose for which it is given or for 60 days, whichever is sooner. No further confidential information will be released without the execution of an additional written statement of consent.

_____ _____/_____/_____

Patient's Signature (or parent, if minor) Date of Birth