

BAKAL DERMATOLOGY ASSOCIATES, S.C.



DISEASES AND SURGERY OF THE SKIN
ALEXIAN BROTHERS MEDICAL PLAZA
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INFORMED CONSENT FOR DISCLOSURE OF PATIENT HEALTH CARE INFORMATION

PATIENT NAME _____
Last Name First Initial Date of Birth
Home address _____

Release to: _____

THE FOLLOWING INFORMATION:

_____ Information in health care records, excluding HIV/AIDS test results, which may include history and physical examinations, records of care and treatment progress and prognosis, and laboratory results. I understand that this includes information provided by physicians, medical assistants, and any other health care providers in the office.
_____ Other (Specify) _____

THE PURPOSE OF THIS DISCLOSURE IS FOR (Mark one or more):

(A photocopy, fax copy or other mechanical reproduction of this form and signature is as valid as the original)

_____ Further care/service _____ Insurance application _____ Personal use
_____ Insurance Change _____ Payment of Ins. Claim _____ Litigation
_____ Relocation _____ Other (specify reason) _____
_____ Dissatisfied with Bakal Dermatology for the following reason:

- () Too much time spent in waiting room before an appointment
- () Inability to schedule appointments at times most preferable to me
- () Prolonged waiting time on the telephone
- () Insurance/Billing difficulties
- () Less than satisfactory physician attitude/mannerisms
- () Less than satisfactory employee attitude/mannerisms
- () Other/Comment: _____

THIS CONSENT SHALL REMAIN IN EFFECT UNTIL: _____

If not stipulated, I understand that this consent will expire one year from date signed and revocation must be in writing and directed to the release or prior to the release of information.

MEDICAL RECORDS FEE: There is a \$20 handling fee for medical records payable at the time of request. Illinois law also allows an additional per page copying charge which we reserve the right to collect.

Please charge my: () MasterCard () VISA () Discover or () Check Enclosed

Account #: _____

Expiration Date: _____ CVV Code _____

Signature of patient or legal guardian Date Witness

Relationship (if other than patient) _____