Diplomates of American Board of Dermatology
Marcia E. Johnson, M.D. Ph.D.
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Medical Records Authorization and Release

Patient Information:
Name_____D.O.B._____
Address_____
City, State, Zip_____

I request a copy or summary of the following medical records:

- ☐ Complete Medical Record
- ☐ Biopsy Report(s)
- ☐ Lab Report(s) Consultation
- ☐ Reports
- ☐ Medication Allergies Allergy
- ☐ Test/Treatment Surgical
- ☐ Procedures
- ☐ Other _____

Please check one:

- ☐ For dates of service from_____/____/_____to ___/____/_____
- ☐ For all dates of service

Reason for request:

- ☐ Personal
- ☐ For Primary Care Physician
- ☐ Transfer to Another Dermatologist (*Please specify reason)* _____

As a courtesy, Deerfield Dermatology does not charge a copying fee if records are less than 15 pages. A reasonable copying fee, as permissible by state law, will be charged if records are ***more than*** *15 pages.*

To ☐ or from ☐
Deerfield Dermatology Associates, Ltd. 707 Lake Cook Road Suite 280, Deerfield, IL 60015 Phone: (847) 480-0004 Fax: (847) 480-8707
To ☐ or from ☐

Name_____
Address_____
Fax Number_____

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Deerfield Dermatology Associates, Ltd. You should contact the office manager to terminate this authorization.

Potential for Redisclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent.

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Signature of patient/Authorized Representative **Date**