ABC Pediatrics, Ltd.

1331 W. 75th Street, Suite 300, Naperville, IL 60540
Telephone: 630-355-0003 Fax : 630-355-9822

Authorization for Release of Confidential Health Information

Patient/s: _____ Date of birth: _____
Address: _____ Telephone:_____
City/State/Zip: _____

I hereby authorize the protected health information regarding the above-named person to be exchanged to:

Person/Institution/Other: _____
Address: _____
City/State/Zip: _____

I authorize the release of information pertaining to the following time periods:

From date(s): _____ To date(s): _____

The following types of information to be disclosed are as follows (check all that apply):

- ☐ History and physical examination
- ☐ Consultation reports
- ☐ Progress notes
- ☐ Operative reports
- ☐ Diagnostic reports (labs, x-rays, etc.)
- ☐ Immunizations only (No Charge)

The following highly CONFIDENTIAL items must be checked off to be included in the disclosure:

- ☐ HIV/AIDS related health information/records (410 ILCS 305/9)
- ☐ Behavioral or mental health information/records (740 ILCS 110/1 et seq)
- ☐ Drug/alcohol diagnosis, treatment, referral information (20 ILCS 301/30.5; 42 CFR Pt. 2)

Reason for the records request: _____
Authorization expires (date): _____ (If not specified, release expires 1 year from the date of signature)

- I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.
- I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.
- I understand that this authorization is valid until it expires, unless revoked before that.
- I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclosure my health information. Written revocation must be sent to the physician's office.
- I have read and understood the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I knowingly and voluntarily authorize ABC Pediatrics, Ltd. to use or disclose my health information in the manner described above.
- I agree to pay $25.00 copying fee for each child's records requested.

Printed name of patient, legal guardian, or authorized agent: _____

Signature of patient or legal guardian, or authorized agent: _____

Date: _____ Relationship to patient: _____

For Office Use Only

Task	Date	Initials
Signed authorization		
Fee paid		
Doctor pull records		
Records copied		
EMR records printed		
EMR immunizations printed		
EMR scanned items printed		
Records Mailed	Faxed	Picked up

Mastercard/Visa/AMEX/Discover

Card Number
Expiration Date