ABC Pediatrics, Ltd.

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Authorization for Release of Confidential Health Information

Patient/s:____

Address:____ Date of Birth/s:______________________

City/State/Zip:____ Telephone:__________________________

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

Person/Institution/Other:____

Address:____

City/State/Zip:_________________________ Telephone:____________________________

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

From dates:___________________________ To dates:_____________________________

The following types of information to be disclosed for no charge if picked up or faxed:

- ☐ Immunizations
- ☐ Growth Charts
- ☐ Most recent physical examination
- ☐ Most recent office visit
- ☐ Problem List

To request the complete record, I agree to pay a processing fee of $25.00 per patient: ☐Yes ☐No

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 request: ____

Authorization expires (date):_______________________ (If not specified, release expires one 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.

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

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

Date: ________________________________ **Relationship to patient:** ___________________________

For Office Use Only

Task	Date	Initials
Signed authorization		
Fee paid		
Records Mailed Faxed Picked up		

Mastercard/Visa/AMEX/Discover	
Card number	Exp. Date