AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Release of Records from Previous Facility

PEDIATRIC HEALTH ASSOCIATES, LTD.

Please fill in form completely:

I,_____, AUTHORIZE_____
(print patient name) (name of facility to release records)

TO RELEASE COPIES OF MY MEDICAL RECORDS TO THE FOLLOWING:

Pediatric Health Assoc., Ltd.
636 Raymond Drive, Suite 205
Naperville, IL 60563

Fax: 630-717-9638
Phone: 630-717-2300

Purpose or need for information:
_____

Patient Name: _____ DOB: _____

Complete Address: _____

_____

Phone Number: _____

Records to be Released:
_____

Please be aware that there may be a charge from your previous physician's office for this service.

I understand that the information to be released may include diagnosis, evaluation and/or treatment for alcohol and or drug abuse, records of HIV and other STD tests and treatment, psychiatric/psychological records or evaluation including treatment for mental, physical and/or emotional illness. If you do not wish to have the above information released, please initial here: _____

I also understand that this Authorization is subject to revocation by me at any time in writing to the medical record contact person at this facility to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked, but will expire 90 days after signing. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information except in instances defined in the Joint Notice of Privacy Practices.

Signature of Patient/Guardian_____

Relationship to Patient _____

Date _____