DuPage Pediatrics, Ltd.

HIPAA COMPLIANT REQUEST & AUTHORIZATION TO RELEASE PROTECTED MEDICAL INFORMATION

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Patient Name   Date of Birth   Phone Number

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Address   City   State   Zip Code

I hereby give DuPage Pediatrics, Ltd. permission to release the above patient's Protected Health Information (PHI) to:

Facility / Physician / Person: ____

Address____

City __________________________ State ________ Zip Code______________ Phone Number_____________________

(Full name & address must be complete to release records)

PLEASE SELECT ONE:

☐ I authorize the last 3 years of medical records, along with immunizations, growth charts and medical summary to be released to the entity listed above unless otherwise specified below.

OR

☐ I authorize the following records to be released to the entity listed above:

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STD/HIV, Behavioral Health, Genetic Testing and Drug/Alcohol Abuse treatment information contained within the dates of service I have specified above ***are to be released through this authorization unless specified below***:

DO NOT RELEASE (check all that apply):

☐ Treatment of STDs (Sexually Transmitted Diseases) and/or HIV testing results ☐ Genetic Testing

☐ Drug or Alcohol Abuse ☐ Psychiatric Issues

This authorization expires ninety (90) days from signature, or at the following event ____.

I am requesting the above patient's protected health information to be disclosed for the following purpose:

☐ For a Second Opinion ☐ Age ☐ Specialist ☐ Residence Moved ☐ Dissatisfied with Care Received

☐ Change in Insurance-Name of New Insurance Company:____

☐ Other ____

I may revoke this authorization at any time by mailing or personally delivering a signed written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

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Signature of Parent/Guardian (if patient is under 18 years old)   Relationship of Person Signing to Patient   Date
Signature of Patient (if patient is 18 years or older)

Cost of Copying Records $_______________ Payment Type__________________ Date Paid______________________________

Date Records Sent_____________________ Sent by ___________ Physician Approval___________________________________