PATIENT AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION TO 3RD PARTIES

By signing this release, I authorize _____ to release the following protected health information (PHI) about my child to A to Z Pediatrics, LLC (Fax: 618-344-9246 or mail to 1230 George E. Chance Parkway, Caseyville, IL 62232 Attn: Medical Records)

☐ COMPLETE MEDICAL RECORDS.

☐ MEDICAL RECORDS FOR THE PERIOD FROM _____ TO _____.

☐ IMMUNIZATION RECORDS ONLY TO:_____.

☐ OTHER SPECIFIC MEDICAL INFORMATION AS DESCRIBED:_____

_____.

My reason for disclosure:

☐ TRANSFER OF CARE TO ANOTHER PHYSICIAN:_____.

☐ CONSULTATION / REFERRAL TO ANOTHER PHYSICIAN:_____.

☐ PRECERTIFICATION / VERIFICATION OF INSURANCE:_____.

☐ IMMUNIZATION RECORDS ONLY

Disclosure of confidential information, *please initial all that apply*:

☐ I consent to the disclosure of medical information that may include chemical or alcohol dependence or psychiatric care, including ADD/ADHD.

☐ I consent to the disclosure of medical information that may include blood tests that have been done to detect antibodies to or levels of HIV which is the probable cause of AIDS (Acquired Immune Deficiency Syndrome)

This authorization will expire 60 days from today's date: _____/_____/_____

When my child's information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that A to Z Pediatrics has acted in reliance upon this authorization (information released prior to revocation). My written revocation will be submitted to the Privacy Officer, A to Z Pediatrics, LLC, 1230 George E. Chance Parkway, Caseyville, IL 62232.

I understand that any fees assessed for copying records of the PHI are my responsibility. Fees are determined by Illinois Public Act 92-228. Future further releases of the information requested at this time will be subject to additional fees. The recipient of this PHI will also require consent of patient, parent or legal guardian for further release. I understand that I/my child will not be denied treatment if I do not sign this authorization for requested use and disclosure of PHI.

Child's name:_____ Child's DOB:_____/_____/_____

Child's SS#:_____-_____-_____ Printed name of parent / guardian:_____

Signature of parent / guardian:_____