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

• Please include the doctor name, practice name, address, phone number and fax number for your new physician. • This form needs to be filled out completely or records will not be transferred. • We will not contact you for a corrected form.	• There will be a $15 charge for all records requests sent via electronic media (email, ftp, fax or disk) to your new physician. • Paper records (via mail or pick up) are charged according to Illinois Statute and must be paid for in full prior to being mailed. (Immunization records will be sent at no charge)

By signing this release, I authorize A to Z Pediatrics, LLC to release the following protected health information (PHI) about my child to:

_____.

___ 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

Information pertaining to ADHD, HIV/AIDS, and testing for Acquired Immune Dificiency Syndrome will be included unless otherwise specified. If you do NOT want this information released, please initial here:_____

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:_____