Associated Pediatric Partners SC
Authorization to Release Medical Records

Name of Patient _____ Date(s) of Service _____

Address:_____

Date of Birth _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care	Military	Social Security/Disability
Insurance	Personal Use	Other: _____
Legal Purposes	School	

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical	Consultation Report	Emergency Room Record
Operative Reports	Discharge/Death Summary	Face Sheet
Lab/Path Reports	X-Ray Reports/Images	Other: _____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

_____

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____

Address (Street, City, State and ZIP)

FROM:

ASSOCIATED PEDIATRIC PARTNERS SC
1310 SHERMER RD, NORTHBROOK, IL 60062
PHONE 847-498-3434
1613 BARCLAY BLVD, BUFFALO GROVE, IL 60089
PHONE 847-520-5400

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

This authorization will expire 90 (ninety) days from the date of my signature, unless I revoke the authorization in writing prior to that time.

Date: _____ Signature: _____
Patient or Legally Authorized Representative

_____
Printed Name of Patient or Legally Authorized Representative

_____
Relationship to Patient