Associated Pediatric Partners, S.C.

Authorization for Release of Patient Health Information

Patient's Name: ____________________________ Date of Birth: __________________ Date: _______________

Address: ____ Phone: _______________________

Email: ____

Please list who will receive this record:

Office/Facility: ____________________________________ Phone Number: _________________________

Address: ____

Method of Delivery (choose one if EHR sharing not available):

___ US Mail ___ Fax (provide number) _______________ Pickup at: ___ Northbrook Office ___ Buffalo Grove Office

Email to: ___________________________________ Who will pick up: ___________________________

Reason for Request: ___ Moving out of area ___ Dissatisfied

___ Seeing a specialist/internist ___ Other (please explain): ______________________

Choose information to be disclosed by Associated Pediatric Pediatrics SC:

Type of Records Requested: (A Records Fee May Apply) **(Please check ONE)**

___ Camp Form ___ School/Sports Form ___ Immunization Record

___ Growth Chart ___ Allergy History ___ Lab Results

___ Entire Health Record ___ Other (please explain): ____

Dates of Service Requested (last 4 years of visit notes is default), or from: _____________ to ______________

Signature of patient or legal representative: ____

Relationship to patient: ________________________________ Date: ________________________

Patient Signature ____ Date: ________________________
(12 yrs. or older if sensitive information is requested)

Sensitive Information: I understand that the information in my record may include information related to sexually transmitted diseases, AIDS/HIV, birth control, and drugs/alcohol diagnosis, treatment and/or referral information. It may also include information about behavioral or mental health services.
Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information may then not be protected by federal confidentiality rules. I understand and accept full responsibility for the medical records I am requesting, and relinquish Associated Pediatric Partners S.C. of all accountabilities concerning these records.
Expiration: If I do not specify an expiration date, event, or condition, this authorization will expire twelve (12) months from the date signed. Unless otherwise revoked, this authorization will expire on the following date: _____________________.
Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing, and I understand the revocation will not apply to information already released based on this authorization.

For office use:
Reviewed by: Initials:_______ Date: __________ Record Fees Due:________ Amount Paid: __________ Rcvd By:________