PEDIATRIC HEALTH PARTNERS, S.C.
10436 SOUTHWEST HIGHWAY CHICAGO RIDGE, IL 60415
(708) 636-0700; FAX (708) 636-3849

AUTHORIZATION TO RELEASE MEDICAL RECORDS

FROM: Pediatric Health Partners, S.C.
10436 Southwest Highway, Chicago Ridge, IL 60415

TO: _____
(PRACTICE / DOCTOR'S NAME)

ADDRESS: _____
STREET/CITY/STATE/ZIP

PHONE: _____

PERMISSION IS HEREBY GRANTED FOR RELEASE OF MEDICAL INFORMATION

PLEASE PRINT CLEARLY

*** PATIENT'S NAME** _____ **D.O.B.** _____
(FIRST) (MIDDLE NAME) (LAST)

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

*** The following information may be released: (check)**

_____ **All Records**
_____ **Laboratory / Radiology**
_____ **Progress / Doctor's Notes**
_____ **Immunization Records**
_____ **Other** _____
(SPECIFY)

* This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signed _____ Date _____
Authorized Signature (If not patient, state relationship)

* I recognize that the records may contain **drug / alcohol information** that is protected by federal and state law. I specifically consent to disclosure of such information.

Signed _____ Date _____
Authorized Signature (If not patient, state relationship)

* I recognize that the records may contain **sexually transmitted disease information**. I specifically consent to disclosure of such information.

Signed _____ Date _____
Authorized Signature (If not patient, state relationship)

* I recognize that the records may contain **mental health information** that is protected by federal and state law. I specifically consent to disclosure of such information.

Signed _____ Date _____
Authorized Signature (If not patient, state relationship)

Co-signed _____
Must be signed by patient 12 years of age or older

Witness _____

FOR OFFICE USE ONLY
Date Received _____ Completed by _____ Date Sent _____
(Initials)

Charges may apply as per Illinois State Comptroller Guidelines

04/22/13 PHP