OAK PARK PEDIATRICS LTD

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize you to release confidential health information about my child by releasing a copy of her or his medical records or other protected health information (PHI), to the person(s) or entity listed below.

Name of child:	Date of Birth:

Please release the following information:

_____ **complete medical record** (to include immunization record).

_____ fax immunization record only

_____ other (specifically describe the information to be used or disclosed, such as date[s] of services, type of services, level of detail to be released, origin of information, etc.):

_____

We cannot disclose certain information unless specifically authorized to disclose this information. Please initial next to each item below if you specifically authorize the release of heath information relating to the testing, diagnosis, or treatment for:

_____ HIV/AIDS
_____ Drug and alcohol abuse
_____ Mental health/psychiatric disorders

This information is to be released from: ____ to: _____ from: _____ to:_____

Name:		Telephone:
Address:		Fax:
City:	State:	Zip:

Oak Park Pediatrics Ltd.
1107 Chicago Avenue
Oak Park, IL 60302
Phone (708) 383-2900
Fax (708) 383-2969

Release information via: ____ pick up ____ mail _____fax immunization record only

I do not have to sign this authorization in order for my child to receive treatment from Oak Park Pediatrics Ltd. I understand that the party releasing information may charge a fee for preparing and furnishing this information

Unless revoked in writing, this authorization will expire after 60 days or upon receipt of the requested medical record from the party to whom information is directed to be released.

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability act of 1996. The party authorized to release information, its employees, officers and physicians are hereby released from any legal responsibility for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Print Name of Parent or Legal Guardian Relationship to Patient