Authorization for use or disclosure of protected health information

Children's Medical Group, S.C.

I, _____, **authorize** _____(facility name) **to release**:

☐ my health information (DOB__/__/__) Doctor's Name (if not listed above):_____

☐ my minor child(ren)'s or patient for whom I am the authorized representative

Name _____ DOB __/__/___ Name _____ DOB __/__/___

Name _____ DOB __/__/___ Name _____ DOB __/__/___

as described below, **to the following recipient**: _____Children's Medical Group, SC_____located at

Address: ____301 N Randall Road_____ City: ____Lake in the Hills_____ State: __IL___ Zip: ___60156___

Phone: __847-658-6065____ Fax: ____847-658-6136____

PURPOSE OF THE REQUESTED USE OR DISCLOSURE: (which may be subject to copying fees in accordance with state laws)

□Legal □Insurance □Personal □Medical Treatment □ Transfer ☐ Other *(please specify)*_____

If transferring, reason for transfer: _____

_____

DESCRIPTION OF INFORMATION:

I request that the information from dates_____ to _____to be used or disclosed consist of the following

CHECK ALL THAT APPLY:

☐ Complete Medical Record ☐Medical History, Consultation/Evaluation Records ☐ Diagnostic Imaging

☐ Laboratory/Pathology Reports ☐Hospital Records Including Reports ☐ Immunizations

☐ Summary of Records ☐Other (Specify):_____

RELEASE OF SPECIFICALLY PROTECTED HEALTH INFORMATION (<u>if applicable</u>):

If the information described above includes information in any category below*, I specifically authorize the disclosure of such information. Please indicate specific information to be used or disclosed and sign where indicated***.**

☐HIV/AIDS testing ☐Genetic testing ☐Records for mental health counseling & therapy/Alcohol & drug abuse/STDs

_____ _____ _____

Signature of patient/Legal representative Relation to patient Date

EXPIRATION: This authorization will expire automatically 3 years on the date following signature or event that relates to me or the purpose of disclosure.

INDIVIDUAL'S RIGHTS RELATING TO THIS AUTHORIZATON:

I understand I may revoke this authorization by notifying the Medical Records Department at any time in writing, but if I do it won't have any effect on actions taken by Children's Medical Group, SC before they received the revocation. I may refuse to sign this authorization. My health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form (except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party). I have a right to receive a copy of this form after I have signed it. By signing this authorization form, I authorize the use or disclosure of my protected health information as described above. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I have had an opportunity to review and understand the content of this authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

_____ _____

PATIENT'S OR REPRESENTATIVE'S SIGNATURE PRINTED NAME

_____ _____

REPRESENTATIVE'S RELATIONSHIP (IF APPLICABLE) DATE