DUPAGE PEDIATRICS, LTD.

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HIPAA COMPLIANT REQUEST & AUTHORIZATION
TO RELEASE PROTECTED MEDICAL INFORMATION TO DUPAGE PEDIATRICS, LTD.

Patient Name: _____ Date of Birth: _____ Phone Number: _____

_____

Address City State Zip Code

I hereby give:

Facility/ Physician/ Person: _____

Address _____

City: _____ **State:** _____ **Zip** _____ **Phone** _____

(Full name & address must be complete to release records)

permission to release my child's Protected Health Information (PHI) to DuPage Pediatrics, Ltd.

I authorize the specific records chosen below to be released to the entity listed above:

- ☐ Complete Record
- ☐ Primary Care Physician Notes
- ☐ Service from _____ through _____
- ☐ Immunization Record
- ☐ Other _____

HIV, behavioral health, or drug and alcohol abuse/treatment information contained within the dates of service I have specified above *are to be released through this authorization unless specified below:*

DO NOT RELEASE RECORDS RELATED TO: (check all that apply)

- ☐ STIs / STDs (Sexually Transmitted Infections/ Diseases) and/or HIV Testing Results
- ☐ Drug or Alcohol Abuse
- ☐ Psychiatric/Behavioral Health Treatment

This authorization expires ninety (90) days from signature, or at the following event _____ .

I am requesting that my child's PHI to be disclosed for the following purpose:

- ☐ For a Second Opinion
- ☐ Age
- ☐ Specialist
- ☐ Moved Residence
- ☐ Dissatisfied With Care Received
- ☐ Change in Insurance-Name of New Insurance Co. _____

I may revoke this authorization at any time by mailing or personally delivering a signed written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

_____

Signature of Parent/Guardian Relationship to Patient Date