DU PAGE PEDIATRICS, LTD

HIPAA COMPLIANT REQUEST & AUTHORIZATION TO RELEASE PROTECTED MEDICAL INFORMATION

Patient Name | Date of Birth | Phone Number

Address | City | State | Zip Code

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

Facility / Physician / Person: _____

Address_____

City _____ State _____Zip _____Phone_____

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

I authorize the specific records chosen below to be released to the entity listed above: Please choose only ONE.

- ☐ Complete Record
- ☐ Primary Care Physician Notes
- ☐ Service from _____through _____
- ☐ Immunization
- ☐ Other_____

STD/HIV, Behavioral Health, Genetic Testing and Drug/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: (check all that apply)

- ☐ Treatment of STDs (Sexually Transmitted Diseases) and/or HIV testing results
- ☐ Drug or alcohol abuse
- ☐ Psychiatric Problems
- ☐ Genetic Testing

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

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

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

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 (Patient Must Sign if at Least 18 Years Old) | Relationship to Patient | Date

Cost of copying records$_____ Payment Type_____ Date Paid_____

Date Records Sent_____ Sent by _____ Physician Approval_____