

Patient Name _____
Address _____
City, State, Zip _____
Telephone # _____
Date of Birth _____

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

I hereby authorize that the protected health information regarding the above-named person be forwarded:

FROM: Person/Institution _____
Address _____
City _____ State _____ Zip _____
Telephone #: _____

TO: Biskup & Segui Pediatric Partners, P.C.
20325 S. Graceland Lane, Frankfort, IL 60423
Tel #: 815-469-8700 Fax #: 815-469-9340

Disclosure will include: (check all that apply) All Records & Immunization Records _____

- | | | |
|---|---|--|
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> History and Physical | <input type="checkbox"/> Laboratory Report |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Progress/Physicians Notes |
| <input type="checkbox"/> X-Ray/MRI/CAT Report | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Emergency Report |
| <input type="checkbox"/> Nurses Notes | <input type="checkbox"/> EKG/EMG/EEG Report | <input type="checkbox"/> Consultation Report |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Other | |

Records for the period (dates) from _____ to _____

I understand that the information to be released may include: (initial all that apply)

- _____ Diagnosis, evaluation and/or treatment for alcohol and/or drug abuse
- _____ Records of HTLV-III or HIV testing (AIDS test) results, diagnosis and/or treatment
- _____ Psychiatric, psychological records or evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans and/or evaluation.

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked but will expire in one (1) year after signing. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

Patient Name _____ Date _____

Signature of Parent/Legal Guardian/Personal Representative _____ Relationship to Patient _____

Witness

REDISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization and the recipient named above that this health information disclosed under this Authorization may be re-disclosed by the recipient to others. Federal law, rules and regulations prohibit the recipient from further disclosing any health information that may be included regarding treatment for drug/alcohol abuse.