Patient Name_____

Address_____

City, State, Zip_____

Telephone #_____

Date of Birth_____

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMTION

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

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

TO: Person/Institution_____

(Recipient) Address_____

City_____ State_____ Zip_____

Telephone #:_____ Fax #:_____

REASON FOR LEAVING THE PRACTICE:_____

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

___ Face Sheet
___ Operative Report
___ X-Ray/MRI/CAT Report
___ Nurses Notes
____Immunization Records
___History and Physical
___ Discharge Summary
___ Pathology Report
___ EKG/EMG/EEG Report
___ Other
___ Laboratory Report
___ Progress/Physicians Notes
___ Emergency Report
___ Consultation Report

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** **Relationship to Patient**

_____ _____
Signature of Parent/Legal Guardian/Personal Representative **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.

For Office Use Only: Received on: Reviewed by (initial): Mailed on: Faxed on: