**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 #**_____ **Fax #**_____

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

**Disclosure will include: (check all that apply)** ___All Records and Immunization Records

| | | |
|---|---|---|
| ___History & Physical | ___Laboratory Report | ___In-Hospital Notes |
| ___Operative Report | ___Discharge Summary | ___Progress/Physicians Notes |
| ___X-Ray/MRI/CAT Report | ___EKG/EMG/EEG Report | ___Emergency Report |
| ___Consultation Report | ___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, treatments 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.