East Suburban Pediatrics

MEDICAL RECORDS RELEASE FORM

Patient Name:_____ Date of Birth:_____

1. I authorize East Suburban Pediatrics to disclose the above-named individual's protected health information as described below:

2. The type of information to be used or disclosed is as follows (check and/or include description)

    1. _____ All Records
    2. _____ Records only from (date) _____ to (date) _____
    3. _____ Records pertaining to (describe) _____

3. I understand that the information in my health record may include information relating to pregnancy, sexually transmitted disease, AIDS, AIDS related syndromes or HIV testing. It may also include information about behavior or mental health services, alcohol, drugs, psychiatric and psychological information.

4. Release records for use by or disclosure to:

    Provider: _____

    Provider Address: _____

    Phone: _____ Fax: _____

5. Disclosed information will be used for the following purpose:

    _____ Transfer of care due to dissatisfaction with the practice
    _____ Transfer of care due to relocation or insurance change
    _____ Specialist consultation
    _____ Legal
    _____ Other (please describe) _____

6. I understand that once the above information is disclosed it may be re-disclosed by the recipient and may no longer be protected by federal or state privacy regulations.

7. I understand that I have the right to revoke this authorization at any time by presenting my written revocations to the Privacy Official. I understand that the revocation will not apply to information that has already been released in response to this authorization.

8. This authorization will expire on the following date _____. If I fail to specify an expiration date this authorization will expire in ninety (90) days.

9. I understand that authorizing this disclosure of this health information is voluntary. I need not sign this form to assure healthcare for treatment.

10. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified.

Patient/Parent/Legal Guardian Signature _____ Date: _____

Relationship: _____
Witness: _____ Date: _____