

northsuburban
PEDIATRICS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Address: _____City/State/ZIP: _____

Phone: _____ Email: _____

Information to Be Released To

Name of Individual/Facility: _____

Address: _____City/State/ZIP: _____

Phone: _____Email: _____ Fax: _____

There is no charge for records sent via email. If you would prefer to pick up or have them faxed, we will contact you once they are ready and provide you with the applicable processing fee.

I authorize the release of my medical records, including, as applicable:

- Complete medical record____
- Office/clinic visit notes____
- Laboratory results____
- Imaging/X-rays/MRI/CT reports ____
- Immunization records____
- Other: _____

Specially Protected Information

- Mental/behavioral health records____
- Substance-use-disorder treatment records____
- HIV/AIDS-related information____
- Genetic information____
- Other specially protected information: _____

Dates of Records Requested: From: _____ To: _____

Purpose of Release

- Continuing medical care____
- Transfer of care____
- Insurance purposes____
- Legal purposes____
- Personal use____
- Disability/benefits application____
- Other: _____

I authorize the healthcare provider or facility identified above to release the specified medical records to the person or organization identified in this form.

I understand that:

1. I may revoke this authorization in writing at any time, except to the extent that action has already been taken based on this authorization.
2. The authorization will expire on 90 days after I have signed the form.
3. I understand that information disclosed pursuant to this authorization may be subject to redisclosure as permitted by applicable law.
4. I understand that I may request a copy of this authorization.
5. I understand that I am not required to sign this authorization as a condition of receiving treatment, payment, enrollment, or eligibility for benefits, except where otherwise permitted by law.
6. I understand that certain specially protected records, including certain mental health, substance-use-disorder, HIV/AIDS, genetic, or other sensitive information, may be subject to additional legal requirements for disclosure.

Patient Signature

Signature: _____Date: _____

If signed by someone other than the patient:

Relationship to Patient: _____Authority to Act on Patient's Behalf: _____