Alzein Pediatric Associates

2850 W. 95th St., Suite 400 Evergreen Park, IL 60805
6700 W. 95th St., Suite 250 Oak Lawn, IL 60453
5106 Museum Dr. Oak Lawn, IL 60453
Phone: 708-424-7600 Fax: 708-424-7605
Hassan Alzein, MD Katherine Riff, MD Stephanie Denny PA-C Kathleen Molloy, PA-C
Kaitlyn Frank, APN Kimberly Reule, FNP

Authorization for Release of Medical Records

Patient Information (please print clearly):

Name: _____ DOB: _____

Address: _____

City: _____ State:_____ Zip Code: _____

Phone Number: _____

I. My Authorization

I hereby authorize the protected health information regarding the above named person to be release from:

Name (or title) and organization _____

Address: _____

City: _____State:_____ Zip Code: _____

Phone Number: _____Fax _____

The above party may disclose this health information to the following recipient:

Name (or title) and organization _____

Address: _____

City: _____State:_____ Zip Code: _____

Phone Number: _____Fax _____

Method of record delivery: ☐USPS Mail ☐Fax

☐Pick Up (specify location) ☐ Evergreen Park ☐ Oak Lawn Location ☐ Urgent Care Location

Disclose the following health information.

☐ - All of my health information

☐ - My health information relating to the following treatment or condition:

_____

☐ - My health information covering the period from _____ (date) to _____ (date)

☐ - Other: _____

The purpose of this authorization is:

_____

This authorization ends:

☐ - Authorization is only valid for 60 days

☐ - Other (date) _____

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II. My Rights

Unless revoked, this authorization will expire in 60 days from date of signature on the above authorization or from the date noted above.

I understand that I have the right to revoke this authorization at any time. I understand that if I do revoke this authorization I must do so in writing and present it to Alzein Pediatrics Associates. I understand that the revocation will not apply to any information already released in response to this authorization.

I understand that once Alzein Pediatrics Associates discloses my information to the recipient, Alzein Pediatrics Associates cannot guarantee that the recipient will not re-disclose my health information to a third party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that treatment by any party may not be conditioned upon my signing of this authorization.

I understand there is a fee for processing this authorization request and health information. I understand there will be a fee of $25.00 upon completion of this authorization form. If my child was a patient of Dr. Van Koinis, I understand this fee is waived.

I will receive a copy of this authorization at my request after I have signed it. A copy of this authorization is as valid as the original.

I have read and understand the terms of this authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Alzein Pediatrics Associates to use or disclose my health information in the manner described above.

_____ _____

Patient Signature Today's Date

<u>If the patient is a minor or unable to sign, please complete the following</u>:

☐ - Patient is a minor: _____ years of age

☐ - Patient is unable to sign because: _____

_____ _____

Signature of Authorized Representative Today's Date

_____

Print Name of Authorized Representative

Authority of representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____