Alzein Pediatrics

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) _____

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 $50.00 upon completion of this authorization form. All accounts should be paid in full before records are released. I understand it may take up to two weeks to complete the transfer of medical records.

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

If the patient is a minor or unable to sign, please complete the following:

☐ - 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: _____