84 Templeton Drive, Suite 106
Oswego, IL 60543
P-630.554.7654
F-630.554.9258

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name _____ Patient Date of Birth _____
Address _____
City, State, Zip _____ Phone _____

I authorize the protected health information regarding the above-named person to be exchanged between:

From:	***To:***
Provider/Institution _____	Provider/Institution _____
Address _____	Address _____
City _____	City _____
State/ZIP _____	State/ZIP _____
Phone _____	Phone _____
Fax _____	Fax _____

Disclosure will include: (check all that apply)
__ All records- (Includes, but not limited to HIV, Mental Health and Substance Abuse Information)
__ History & Physical ___ Lab Reports __Immunizations
__ Progress Notes ___Radiology Reports __Substance Abuse
__ Mental Health
__ Other _____

Information in checked boxes may be released from:
__ All Dates
__ Records for the period (dates) from _____ to _____

Purpose of this information is:
__ Seeking care from a specialist physician
__ Relocation: My new address is _____
__ New insurance and must transfer care: My new insurance is _____
__ Other (please specify): _____

This authorization expires:
__ On (date): _____
__ When the following event occurs: _____
__ In 90 days from the date signed.

I also understand that this authorization is subject to revocation/withdrawal by me at any time in writing to Apple-a-Day Pediatrics except if the action has already been taken to release the information. I have the right to inspect a copy of the health information to be released. My child's treatment, payment or eligibility may be conditioned on obtaining the authorization. Apple-a-Day will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others. Once health care information is disclosed, the person or organization that receives it, may re-disclose it. Privacy laws may no longer protect it.

I understand that there may be a fee required for this request.

Parent/Legal Representative Signature: _____

Date: _____