Pediatric And Youth Healthcare

Authorization to Release Protected Health Information

The Protected Health Information disclosed by our office staff to the desired recipient has the potential to be re-disclosed and therefore no longer will be protected. This authorization can be revoked at any time in writing to A to Z Pediatric and Youth Healthcare, but this will not effect information previously disclosed. This authorization is not needed in order to render treatment, eligibility, or payment for patient. The expiration for this authorization will expire in 1 year from _____ to _____. You are allowed to get a copy of the information disclosed, except the information that was obtained from a child under confidential promise. If you are the patient's representative, we are required to include court orders,power of attorney for healthcare papers, death certificate, estate papers, guardianship papers, adoption papers, etc.

I, _____, am stating that through this document that I am the person authorized to act

on behalf of the patient:_____, with date of birth _____ and I hereby authorize the following party:

_____
(Previous Provider that has the Protected Health Information's Name and Complete Address)

to release the following limited information specified below with a check mark and date range pertaining to

_____ with date of birth of _____ to:

___A to Z Pediatric and Youth Healthcare, 721 W. Lake St., Suite 202, Addison,IL 60101 Fax:630)757-4011 _
(Current Provider that will receive the Protected Health Information's Name and Complete Address)

Information Authorized (*Please check all that apply and put the date range):*

[ ] Medical Record from _____ to _____, which includes
[ ] Immunizations [ ]Prescriptions [ ]Lab Results [ ] Growth Charts [ ] Physicians Notes

[ ] Mental Health Information from _____ to _____.

[ ] Education Information from: _____ to _____.

[ ] Financial Records from _____ to _____.

[ ] Other:_____ from_____ to _____.

Signature of patient minor (12 to 17 years):_____

Signature:_____ Date:_____
Patient*, Parent, Guardian, Representative

Address of Patient*, Parent, Guardian, Representative authorizing the disclosure of information:

_____

Signature:_____ Date:_____
Witness