Healthy Beginnings Pediatrics
1200 W. US Highway 34Plano, IL 60545
Phone: 630-599-7533 Fax: 630-599-7534

Authorization for Release of Medical Records

PATIENT INFORMATION

Patient Name:_____ D.O.B_____
Address:_____
Phone:_____ SS#_____

RELEASE FROM (Previous Pediatrician)

Physican/Facility:_____
Phone:_____ Fax:_____

PLEASE SEND RECORDS TO

Physician/Facility: Healthy Beginnings Pediatrics 1200 West US Highway 34 Plano, IL 60545
Phone: 1-630-599-7533 Fax: 1-630-599-7534

Release Information/Records for the period (dates) From:_____ To:_____

REASON: ( ) Change of insurance ( ) Transfer of care ( ) Moving out of area
( ) Specialist consult ( ) Person file ( ) Legal

Information to be disclosed:

___ Entire medical records INCLUDING mental health treatment, alcoholism, drug abuse treatment, and HIV/Acquired immune deficiency syndrome (AIDS) records.
__ Entire medical record EXCLUDING mental health treatment, alcoholism, drug abuse treatment, and HIV/Acquired immune deficiency syndrome (AIDS) records.
___ Laboratory reports only
___ Radiology reports only
__ Immunization records
__ Other _____

I understand that I have the right to inspect the information I have authorized to be released. In the event I refuse to authorize the release of the above describe information, I understand that it will not be disclosed, except as provided by law.

I understand that the practice may not condition treatment on whether I sign the authorization, except when the provision of healthcare is solely for the purpose of creating protected health information for disclosure to third party.

I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician's has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such written revocation, this Authorization for Release of Medical Information will terminate 90 days from date of signature.

Signature: _____ Date:_____