Bard and Didriksen Pediatrics Authorization for Practice to Release Protected

2160 IL-157, Suite B, Glen Carbon, IL 62034 Health Information to Third Parties

(618) 692-1212

1. PATIENT INFORMATION:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Address City State Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth Cell Phone Cell Phone

1. AUTHORIZES:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Health Care Provider / Other

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address

1. TO DISCLOSE TO:

\_\_\_\_\_Legal Guardian/Self Delivery Options: \_\_\_\_\_Pick-up \_\_\_\_\_Mail

\_\_\_\_\_Send to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of Health Care Provider / Other

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address

1. DATE(S) OF INFORMATION TO BE DISCLOSED: From\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If left blank, only past (2) Years will be disclosed. (Month / Year) (Month / Year)

1. INFORMATION TO BE DISCLOSED:

\_\_\_\_\_ Complete medical records including records relating to mental health, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.

\_\_\_\_\_ Complete medical records excluding the following:

 \_\_\_\_\_ Mental Health Records

 \_\_\_\_\_ Communicable Disease (including HIV and AIDS)

 \_\_\_\_\_ Alcohol/drug abuse treatment

 \_\_\_\_\_ Other (Please Specify)

1. EXPIRATION OF AUTHORIZATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (no more than 60 days from today)

When my child’s information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and my no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Bard and Didriksen has acted in reliance upon this authorization (information already released prior to my written revocation). My written revocation will be submitted to the Privacy Officer, Bard and Didriksen Pediatrics, 2160 IL-157, Suite B, Glen Carbon, IL 62034 (618) 692-1212

I understand that any fees assessed for copying records of the required PHE are my responsibility. Fees are determined by Public Act 92-228. Future releases of the information requested at this time will be subject to additional fees. The recipient of this PHI will also require consent of the patient parent / guardian for further release. I understand the I/my child will not be denied treatment if I do not sign this authorization for requested use and disclosure of Protected Health Information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Patient / Legal Guardian Relationship to Patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Patient / Legal Guardian Printed Name of Patient if a minor