Authorization for Release of Patient Health Information

Section 1. Patient Information:

Patient Name _____ Patient Date of Birth _____

Address _____

City / State / ZIP _____

Telephone # _____

Section 2. I authorize the protected health information to be released as follows:

To be released to:	**To be released from:**
Pediatric Associates of the North Shore 1144 Wilmette Ave Wilmette, IL 60091 Tel 847-256-6480 Fax 847-256-6482 Email info@pansdocs.com	Person / Institution: Address City/ State / ZIP Telephone #

Section 3. Purpose: The purpose of this disclosure is:

Sharing with current health care providers

Section 4. Date Range: I authorize the release of information covering the period(s) of treatment:

From Date: _____ To date: _____

Section 5. The type of general health information to be used or disclosed is as follows (check all that apply):

❑ Progress Notes ❑ History and Physical Examinations ❑ Immunization history ❑ Abstract copy (Tests, results, typed reports) ❑ Consultation Reports	❑ Operative Reports ❑ Discharge Summaries ❑ Diagnostic Reports (including labs, radiology, pathology)	❑ Genetic testing information and/or records ❑ Information about child abuse/neglect
❑ Entire available record ❑ Other:		

Section 7. Special Consent: Certain types of highly sensitive information require a special indication from you, in order for us to release that information. Special consent is <u>also</u> required by adolescent patients aged 12-17 years old. Records may be reviewed by the provider prior to release. Providers have the right to deny release if deemed appropriate and in compliance with the law. The legal guardian and patient aged 12-17 must initial each item below for release, and sign at the end of the form:

Guardian Initials	**Type of Information**	**Patient age 12-17 initials**
	HIV/AIDS related health information and/or records	
	Sexually Transmitted Illness information and/or records	
	Sexual Assault/Abuse	
	Birth Control information and/or records	
	Child Abuse/Neglect	
	Behavioral and Mental health information and/or records	
	Drug/alcohol use information and/or records	
	Confidential Communication Note	

Guardian Initials	Substance Use Treatment Information (42 CFR *Part 2*)	Patient age 12-17 initials
	Chemical Dependency Assessments	
	Behavioral Health level of care assessments	
	Medication List	
	Laboratory Reports	
	Pathology Reports	

Section 8. I understand and agree with the following:

- This release will expire within twelve (12) months of the date of the signature.
- I understand authorizing the use or disclosure of the information identified above is voluntary..
- Once the organization or person authorized to receive this information has received it, the information may be re-released by that organization or person. If this is the case, the information may no longer be protected by federal privacy laws; however, that re-release will be subject to Illinois law.
- I understand that I have the right to revoke (take back) this authorization at any time. I understand that if I wish to revoke this authorization, I must contact the records source to do so. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand that I have the right to inspect and obtain a copy of any information about mental health, drug and alcohol, or developmental disability services that is disclosed pursuant to this Authorization.

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 Pediatric Associates of the North Shore to use / access my health information in the manner described above.

Printed Name of Patient age 18 or over *or* Legal Guardian	**Relationship**
Signature of Patient age 18 or over *or* Legal Guardian	**Date**
Signature of Patient age 12 - 17	**Date**
Witness *mental health releases must be witnessed - by anyone other than parent or patient*	**Date**
Signature of Staff *having checked the ID of the signer and ensured that this is the legal guardian/patient*	**Date**