AUTHORIZATION FOR RELEASE OF INFORMATION

*** **EACH** AREA OF THE FORM **MUST** BE COMPLETED ***

AUTHORIZATION FOR RELEASE OF INFORMATION – I hereby authorize the use or disclosure of my health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations.
Treatment may not be conditioned on authorization, except in the case of providing research related treatment.

I, _____hereby give my
(Print Name of Patient or Responsible Guardian)

consent to Suburban Pediatric Therapies to

Release to _____
(Name of Health Care Facility, Physician, Agency or other person to receive records – if copies are to be released to you, please write in your name or "myself")

Address Where to Send _____

_____

Information from the Medical Record of _____
(Patient's Name)

This request will be valid until ____/____/_____ (or no more than 90 days from signature – whichever comes first, or date not entered)

_____ _____
(Patient's Date of Birth) (Patient's Address – unless the recipient address is the same, then this does not need to be completed – just indicate "same")

Paitient/Guradian Phone # _____

SPECIFY DATE(S) AND TYPE OF SERVICE _____

_____

_____

Only Complete the Question below if it APPLIES to your request.

☐ **My Request includes records containing mental health issues, HIV, alcohol and/or drug related information. If requesting release of records containing said information, please initial here _____ .**

For Release of Information Questions Call 630-236-7000

Purpose for release of Information is required to be disclosed (must be indicated)

☐ Continuing Care (Copies should be SENT to Healthcare provider in most cases)
☐ Personal Use (per page charge at current legislated rates for personal copies)
☐ Attorney Use
☐ Other _____

Copies Requested:

☐ Discharge Summary	☐ History/Physical	☐ Physicians Orders	☐ Other, Specify
☐ PT,OT,ST Notes	☐ Accounting of Disclosures	☐ Evaluation	_____
☐ IEP Records	☐ Progress Notes	☐ Consultation	_____

Revocation of this authorization may be given at any time via signed and witnessed written notice to Suburban Pediatric Therapies and/or affiliates. Any such revocation shall have no effect on disclosures made prior to receipt of such revocation. You have the right to inspect or copy any or all information to be sued or disclosed. The choice to sign or refuse to sign this authorization for release of information is yours.

_____ _____
(Patient or Guardian Signature) (Date)

***** If you are not the patient, please print your name below and specify your <u>authority to act on behalf of the patient.</u>**

_____ _____
Print Name **Authority**

You may mail a completed, signed copy of this form to: **OR** You may Fax both sides of this form to:

Suburban Pediatric Therapies
3695 75th Street – Suite 104
Aurora, IL 60504

630-236-7800

***** NOTE: FOR SUBURBAN PEDIATRIC THERAPIES'OFFICE USE ONLY BELOW THIS LINE *****

Witness: _____ Date: _____

Two forms of ID as Witnessed at Request/Pickup: (I.E. Driver's License, State ID, Work ID, etc.)

1. _____ 2. _____

M# _____

Copies Released:

☐ Discharge Summary	☐ History/Physical	☐ Physicians Orders	☐ Other, Specify
☐ PT,OT,ST Notes	☐ Accounting of Disclosures	☐ Evaluation	_____
☐ IEP Records	☐ Progress Notes	☐ Consultation	_____

_____ _____
Printed Name of Staff who prepared records for release Date Released

HIPAA REQUIREMENT: A COPY OF THIS COMPLETED FORM (AFTER SIGNATURES) MUST BE PROVIDED TO THE REQUESTOR

Please read both sides of this form carefully. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), which became effective April 14, 2003, requires that all of the above elements must be completed for an authorization to be valid

<u>For Release of Information Questions Call 630-236-7000</u>