Chicago PEDIATRIC CLINIC

1916 W. Irving Park Rd.
Chicago, IL 60613
(773) 477-4900
(773) 477-1510 - fax

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient(s):

_____ **D.O.B.** _____ _____ **D.O.B.** _____

_____ **D.O.B.** _____ _____ **D.O.B.** _____

I hereby authorize that the protected health information regarding the above-named patient(s) be forwarded:

TO: _____

_____ **Phone #:** _____

_____

Purpose or need for information: ___ New Doctor **Moved to:** _____
___ Specialist _____
___ Other **Phone #:** _____

Disclosure will include: (check all that apply)

☐ Immunization Record ☐ Laboratory/X-Ray Reports

☐ History & Physical Findings ☐ Hospital Records

☐ Consultation Reports ☐ Other _____

I understand that the information to be released may include: (initial all that apply)

___ Records of HTLV-III or HIV testing (AIDS test) result, diagnosis and/or treatment

___ Psychiatric, Psychological records or evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluation.

I release this clinic from all legal responsibilities or liability for disclosure of the above information that may arise from this authorization.

Please be aware of a fee for medical releases:

Handling Charge:	***$33.60***
Copy pages 1 through 25:	***$1.26***
Copy pages 26 through 50:	***$0.84***
Copy pages in excess of 50:	***$0.42***

(Per State of Illinois Comptrollers Office- Copy fees as required under 735 ILCS 5/8-2006)

_____ _____ _____

Signature of Parent/Legal guardian Date Witness

Rev. 05-23