BLOOMINGTON PEDIATRICS AND ALLERGY, LTD.
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BLOOMINGTON, IL 61701
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FAX (309) 663-7645

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____DOB:_____

Patient Name: _____DOB:_____

Patient Name: _____DOB:_____

Street address _____

City, State, Zip:_____Phone #:_____

I AUTHORIZE THE DISCLOSURE OF MY PERSONAL HEALTH INFORMATION AS FOLLOWS:

Party to RECEIVE my health information:

Name: _____

Address:_____

City, State, Zip: _____

Party to RELEASE my health information:

Name:_____

Address:_____

City, State, Zip:_____

PURPOSE OF DISCLOSURE:

Moving to a new location_____ Changing Insurance_____ Other (specify)_____
Specialist Referral_____ Patient Request_____ _____

DESCRIPTION OF MY HEALTH INFORMATION TO BE DISCLOSED:

Routine Records_____ Complete Chart _____ Specific Records Only _____ Specify:_____
_____

This authorization is valid for 1 year unless I cancel this authorization in writing before it expires. The cancellation must be dated and signed. It must be delivered to the Privacy Officer at Bloomington Pediatrics and Allergy, 306 St. Joseph Dr., Bloomington, IL 61701.

I understand the health information disclosed by this authorization may be redisclosed by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

Signature:_____ Date:_____

Relationship if not patient:_____ **WITNESS:_____**