Downers Grove Pediatrics

REQUEST OF MEDICAL RECORDS FROM DGPEDS

HIPAA COMPLIANT REQUEST & AUTHORIZATION TO RELEASE PROTECTED MEDICAL INFORMATION

I HEREBY GIVE DOWNERS GROVE PEDIATRICS, LTD. PERMISSION TO RELEASE MY CHILD(S) PROTECTED HEALTH INFORMATION TO:

Name: _____

Address: _____ **City:**_____, **State:**_____, **Zip:**_____

Phone: _____

PATIENT NAME	DATE OF BIRTH
_____	_____
_____	_____
_____	_____
_____	_____

I am requesting my child's PHI to be disclosed for the following purpose:

☐ For a second opinion ☐ Residence/Moved ☐ Age ☐ Specialist ☐ Dissatisfied with Care Received ☐ Insurance

I authorize the specific records chosen below to be released to the entity listed above:

☐ IMMUNIZATIONS ONLY (NO CHARGE)
☐ COMPLETE CHART
☐ SERVICES FROM _____TO_____
☐ PROGRESS NOTES ONLY
☐ OTHER

HIV, Behavioral Health, or Drug and Alcohol Abuse/Treatment information contained within the dates of service I specified above *are to be released through this authorization unless specified below:*

DO NOT RELEASE: (check all that apply)

☐ Treatment of STDs (Sexually Transmitted Diseases) and/or HIV testing results

☐ Psychiatric Problem

☐ Drug or Alcohol abuse

This authorization expires ninety (90) days from the signature, or at the following event_____:
I may invoke this authorization at any time by mailing or personally delivering a signed written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization. I am entitled to a copy of this authorization upon on my request... I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed my sometimes be re-disclosed by the recipient and my no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

ANY QUESTIONS REGARDING THIS FORM PLEASE CONTACT SUE FERRARO AT 630-852-4551 X19

_____

Signature of Parent/Guardian Relationship to Patient Date

COSTS OF COPYING RECORDS: _____ PAYMENT TYPE: _____DATE PAID_____

RECORDS SENT BY:_____ DATE SENT:_____REVIEWED BY:_____