

Young Pediatrics

Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____

Address: _____

Phone: _____

SSN: _____ Date of Birth: ____/____/____

I authorize the custodian of records of: or other person/entity (specifically describe) to disclose/release the following information* (check all applicable):

- All records
- Laboratory/pathology records
- X-ray/radiology records
- Billing records
- Abstract/Summary
- Pharmacy/prescription records
- Other (describe specifically)

**Note: If these records contain any information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s):

Please send the records listed above:

TO:

Name: **Young Pediatrics**
Address: **4804 South State Route 159**
Glen Carbon, IL 62034

Phone: **(618) 288-9305**

Fax: **(618) 288-9308**

FROM:

Name: _____

Address: _____

Phone: _____

Fax: _____

The information may be used/disclosed for each of the following purposes:

- At my request (only the patient/parent can check this box)
- For my health care
- For payment/insurance
- Change of Primary Care
- Other:

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. **Release expires 1 year from date unless specified other.**

Signature of patient (or patient's personal representative) _____ Date _____

Printed name of patient representative Representative's authority to sign for patient, (*i.e parent, guardian, power of attorney for healthcare, executor*) _____ Date _____