

**Authorization for Release of Health Information**

Patient Name (Print)

Date of Birth (mo / day / yr)

Social Security Number

Telephone Number

I, hereby request and authorize:	To disclose the information identified below to:
Genesis Pediatric Medicine	
Name of person/facility	
1680 Mediterranean Drive, Sycamore IL, 60178	
Mailing address	
(815) 899-0001	
Telephone number	
(815) 899-0002	
Fax number	

Physician notes	Growth charts	Lab reports
Immunization records	Transferred in records	Radiology reports
Other (specify):		

If your health information contains any of the following, please check each category that you authorize to be released. Please confirm your request by placing your initials next to each check and then sign where indicated.

Signature:

AIDS/related illness, diagnosis or treatment	HIV test results
Alcohol/drug abuse diagnosis or treatment	Genetic testing
Psychiatric/mental health or developmental disabilities information	

**Purpose for release:**

Exchange with other health care providers	Changing Healthcare Providers
Insurance processing	Relocation
Insurance change	Legal indications
Other (specify):	

This authorization will be considered valid for a 90 day period following the date of signature unless otherwise specified here; \_\_\_\_\_. I absolve Genesis Pediatric Medicine together with its officers and employees from any legal liability which may arise from the disclosure of this information. You have the right to revoke this authorization except that such revocation will not apply to any uses and disclosures of your information that are described in the Genesis Pediatric Medicine Notice of Privacy Practices or otherwise allowable under any Federal or State laws. In the event of revocation, any prior use of any information up to that date of revocation may not be retracted. A request to revoke this authorization must be made in writing.

.....  
Patient/representative signature

Date

For patients under 18 years of age, unless emancipated, this Authorization (and any revocation) must be signed by a representative who has the legal authority to act on their behalf.

Your relationship to the patient is: \_\_\_\_\_.