genesis
pediatric medicine

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	

I request the following information to be released (check all that apply):

☐ 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: _____.