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Oswego, IL 60543
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize APPLE-A-DAY PEDIATRICS
to release medical information for the named patient(s) to:

Phone: _____ Fax: _____ Email: _____
(for immunization records only)

Child/Children's Names(s)

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

Disclosure will include: (check all that apply)

- All records- (Includes, but not limited to HIV, Mental Health and Substance Abuse Information)
 History & Physical Lab Reports Immunizations
 Progress Notes Radiology Reports Substance Abuse
 Mental Health
 Other _____

Information in checked boxes may be released from:

- All Dates
 Records for the period (dates) from _____ to _____

Purpose of this information is:

- seeking care from a specialist physician
 relocation: My new address is _____
 new insurance and must transfer care: My new insurance is _____
 Other (please specify): _____

This document expires in 60 Days 90 Days or 1 Year from date signed.

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to Apple-a-Day Pediatrics except if the action has already been taken to release the information. I have the right to inspect a copy of the health information to be released, and if I do not sign this Authorization, Apple-a-Day Pediatrics will not release my health information. Apple-a-Day will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

**In accordance with IL Senate Bill 721 effective 9-1-01, reasonable costs will be charged for the request.
*Payment of \$25 for the first child and \$10 for each additional child is required in full before processing.
(REQUEST FOR IMMUNIZATIONS ONLY ARE NO CHARGE)**

Parent/Legal Representative Signature: _____
Date: _____