apple-a-day pediatrics

84 Templeton Drive Suite 106
Oswego,IL 60543
P-630.554.7654
F-630.554.9258

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Apple A Day Pediatrics
to release medical information for the named patient(s) to:

_____

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 $25.00 is required in full before processing.**

Parent/Legal Representative Signature: _____
Date: _____