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## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name \_\_\_\_\_ Patient Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

### Medical Information Requested From:

Apple-a-Day Pediatrics  
 Individual or Organization's Name: \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_ Fax \_\_\_\_\_

### Medical Information Requested To:

Apple-a-Day Pediatrics  Patient listed above  
 Individual or Organization's Name: \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_ Fax \_\_\_\_\_

### Information will be disclosed by:

Encrypted PDF via email to email address: \_\_\_\_\_  
 Secure fax  
 In person pick up (requires photo ID)

### Medical Information to Disclose:

All records  Lab Results  
 Immunizations  Radiology/Imaging Results  
 Essentials Only (last well visit note, immunization record and growth charts)  Admission/Discharge Summaries  
 Progress Notes  Specialist Consult Notes  
 Mental Health

### Information checked above may be released from:

All Dates  From \_\_\_\_\_ to \_\_\_\_\_  
(Only up to the last ten (10) years of medical records will be released)

### The purpose of this release of information is:

Seeking care from a specialist physician  Maintaining communication with PCP  
 Relocation- My new address is \_\_\_\_\_  
 New insurance and must transfer care- My new insurance is \_\_\_\_\_  
 Continuation of care with a new PCP - My new PCP is \_\_\_\_\_

### This authorization expires:

On (date): \_\_\_\_\_  In 90 days from the 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. My child's treatment, payment or eligibility may be conditioned on obtaining the authorization. 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. Once health care information is disclosed, the person or organization that receives it, may re-disclose it. Privacy laws may no longer protect it.

*\*I understand that there may be a fee required for this request.*

Parent/Legal Representative  Adult Patient Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_