



MRN

### Authorization for Release of Protected Health Information (PHI)

Patient Name  Date of Birth

Address  Telephone Number

**I hereby authorize** (Name of facility/provider **releasing** information) **to disclose the above-named individual's health information:**

Ideal Pediatrics, Medical Records 1550 N Main St, Suite E Columbia, IL 62236

**Name (facility releasing information) Address City State Zip**

Telephone Number  618-281-4325 Fax: 618-281-8393

Date(s) of Service Requested (if known) or Provider: \_\_\_\_\_

Description of Information to be released: (check all that apply)

- Progress notes
- Consultations
- Most recent history and physical
- Immunization record
- Other \_\_\_\_\_
- Laboratory reports
- Radiology/Imaging reports
- Radiology films
- Two-way verbal exchange of communication
- Entire medical record

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

**This information may be disclosed to and used by the following individual or organization (receiving the information)**

**Name (facility receiving information) Address City State Zip**

Telephone Number  618-281-4325 Fax: 618-281-8393

Description of the purpose of the use and/or disclosure: (check one)

- Continuing Care
- Consultation
- Legal purposes
- Second Opinion
- Emergency/acute care
- Personal Use
- Social Security/Disability (provide copy of SSA Letter)
- Insurance
- Other: Please describe: \_\_\_\_\_

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I may inspect or copy the information to be used or disclosed, and that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient, and may no longer be protected by federal and state privacy regulations. The Clinic may charge a processing fee for this service. This authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until \_\_\_\_\_ (date or event).

I further understand that I may revoke this authorization at any time by notifying the Health Information Management Department of Ideal Pediatrics. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

\_\_\_\_\_  
**Signature of Patient or Patient's Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed name of Patient or Patient's Representative**

\_\_\_\_\_  
**Relationship to Patient**

**or**

\_\_\_\_\_  
**Legal Authority (attach supporting documentation)**