PARKSIDE PEDIATRICS, S.C.
PATRICIA C. STEC, M.D.
FRANK ROEMISCH, M.D.
1875 DEMPSTER STREET, SUITE 650
PARK RIDGE, ILLINOIS 60068-1168
(847) 823-8000

Patient Name_____

Address_____

_____

Phone Number_____

Date of Birth_____

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

I hereby authorize that the protected health information regarding the above-named person be forwarded:

FROM: Person/Institution_____

Address_____

City_____State_____Zip_____

TO:

Person/Institution_____

(**Recipient**) Address_____

City_____State_____Zip_____

Phone number_____

Reason why changing doctors_____

Disclosure will include:

☐ Entire Medical Record

or only the following:

(*check all that apply*)

☐Laboratory Report ☐ Operative Report ☐Discharge Summary ☐ Progress/Physician Notes ☐X-ray/Radiology Report

☐Pathology Report ☐ Emergency Report ☐EKG/EMG/EEG Report ☐Consultation Report ☐Other _____

Records for the period (dates) from _____to_____

I must check one or more of the following types of health information that I do not want released to the above named Recipient. I understand that if I do not check any of the three (3) following boxes, the health information released to the named Recipient may include any of the following:

☐**Diagnosis, evaluation and/or treatment for alcohol and/or drug abuse**

☐**Records of HTLV-III or HIV testing (AIDS test) result, diagnosis and/or treatment**

☐**Psychiatric, psychological records or evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluation.**

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. Unless revoked earlier or otherwise indicated, the authorization shall remain in effect only for the period reasonably needed to complete the request. I have a right to inspect a copy of the health information to be released. If I do not sign this Authorization, Parkside Pediatrics, S. C. will not release my health information. Parkside Pediatrics, S. C. will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

_____ _____

Signature of Parent/Legal Guardian/Personal Representative **Date**
(Required if Patient is not legally authorized to sign Authorization)

_____

Relationship to Patient

REDISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization that Parkside Pediatrics, S.C. cannot guarantee that the Recipient receiving the requested health information will not redisclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the redisclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.