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Kristy M. Macellio, PA-C

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Please read both sides of this form carefully. The Federal Insurance Portability and Accountability Act of 1996 (HIPPA), which became effective April 14, 2003, requires that all of the following elements must be completed for an authorization to be valid.

Patient(s) Name:____
Date(s) of Birth:____
City, State, and Zip Code: ___________________________, __________, _____________________
Phone Number:____________________________

I hereby authorize that the protected health information regarding the above named person(s) be forwarded to:

From: Person/Organization:____

Address:____
City:____State:________Zip:________________
Phone:________________________________Fax:________________________________

To: Person/Organization: Associated Pediatrics of Fox Valley
Address: 2121 Ridge Ave Suite 101
City: Aurora __State: I L Zip: 60504

Purpose or Need for Information:____

Disclosure to include: (check ALL that apply) ______**Complete Medical Record**

_____History and Physical ______Laboratory Report _____Radiology Report

_____Progress Notes ______Pathology Report _____Emergency Report

In accordance with the Illinois Senate Bill 721 effective 9-01-2001, reasonable costs will be charged for the medical records requested. Your current doctor may require a fee for your medical records. Please contact their office for any additional information they may require prior to sending us your medical information.

Associated Pediatrics REQUIRES ALL PATIENTS TO HAVE AT LEAST THEIR IMMUNIZATION RECORD ON FILE PRIOR TO THE FIRST VISIT.

I understand that 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 following three items, 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-lll or HIV testing (AIDS test) result, diagnosis 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, consultation, treatment plans, and/or evaluation.

I also understand that this Authorization is subject to revocation/withdrawal to me at any time in writing to the medical record contact person at this site of care except to the extent the action has already been taken to release this information. The Authorization shall remain valid unless revoked but *will expire one year after signing*. I have the right to inspect a copy of the health information to be released, and if I do not sign the Authorization, the organization named above will not release my information. The above names person/authorization will not refuse to treat me based on weather I agree to allow my child's health information to be used and disclosed to others.

____________________________________ ________________________
Signature of Parent/Legal Guardian Date

____
Relationship to Patient

Re-Disclosure: Notice is hereby given to the patient or legal representative signing this Authorization that Associated Pediatrics of Fox Valley cannot guarantee that the Recipient receiving the requested health information will not re-disclose any or all of it to others. Notice is hereby given to the Recipient that the law prohibits the re-disclosure of any health information regarding drug and/or alcohol abuse, HIV, and mental health treatment.

COMPLETE ONLY IF TRANSFERRING OUT OF OUR OFFICE:

Please tell us why you are requesting your health information by checking one of the following:

______I am remaining an Associated Pediatrics of Fox Valley patient but also seeking care from an outside physician

_____ I am leaving Associated Pediatrics of Fox Valley Because:

- _____I am moving from the area
- _____I have a new insurance plan
- _____I was dissatisfied with some aspect of Associated Pediatrics of Fox Valley
  Comments: ____