

Nadia Abu-Nijmeh, M.D. • Luis Bolanos, M.D. • HinnaKhan,M.D. • Jennifer Kleinfeld,M.D. •  
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: Associated Pediatrics of Fox Valley  
Address: 2121 Ridge Ave Suite 101  
City: Aurora State: IL Zip: 60504  
Phone: 630-820-7100 Fax: 630-264-2524

**From:** Person/Organization: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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 law with statute 735 ILCS 5/8-2006 effective 1-01-2014, reasonable costs will be charged for the medical records requested. Our fee for medical records is stated below, **due upon request.**

Handling Charges: \$26.38

Pages 1-25 \$0.99 per page

Pages 26-50 \$.66 per page

Pages 50+ \$.33 per page

*Please contact our office for a balance due total 630-820-7100*

PAID:                      Cash                      Check #                      Credit V/M/D

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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-III 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 by 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 in 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 named person/authorization will not refuse to treat me based on whether 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: \_\_\_\_\_