Kids First Pediatric Partners
Concourse Office Plaza, Tower 2
4709 Golf Rd., Ste 900
Skokie, IL 60076
Phone: 847.676.5394 Fax 847.679.7183
www.kidsfirstpediatricpartners.com

Authorization for Release of Patient Health Information

Patient Name ______________________________
Patient Date of Birth ______________________________
Address ______________________________
City / State / ZIP ______________________________
Telephone # ______________________________

I hereby authorize the protected health information regarding the above-named person to be exchanged between:

To ❑ From ❑

Kids First Pediatric Partners
Concourse Office Plaza, Tower 2
4709 Golf Rd., Ste 900
Skokie, IL 60076
Phone: 847.676.5394 Fax 847.679.7183

To ❑ From ❑

Person / Institution ______________________________
Address ______________________________
City, State, ZIP ______________________________
Phone ______________________________
Fax ______________________________

I authorize the release of information covering the period(s) of healthcare from

From (mm/dd/yyyy): ____________________ To (mm/dd/yyyy) ____________________

The type of information to be used or disclosed is as follows:

- ❑ History and physical examination
- ❑ Discharge summary
- ❑ Abstract (*documents summarizing health history*)
- ❑ Immunization record
- ❑ Operative reports
- ❑ Diagnostic reports (*labs, x-rays, etc.*)
- ❑ Growth Charts
- ❑ Verbal only (*please specify*) ______________________________
- ❑ Other (*please specify*) ______________________________

The following highly confidential items must be checked off to be included in the use or disclosure of other health information:

- ❑ HIV/AIDS related health information and/or records (*the patient 12 or over must authorize this release*)
- ❑ Behavioral or mental health information and/or records (*release must be witnessed and the patient 12 or over must authorize this release*)
- ❑ Information about sexually transmitted disease (*the patient 12 or over must authorize this release*)
- ❑ Pregnancy (*the patient 12 or over must authorize this release*)
- ❑ Birth control (*the patient 12 or over must authorize this release*)
- ❑ Drug/alcohol diagnosis, treatment, and/or referral information (*the patient 12 or over must authorize this release*)
- ❑ Genetic testing information and/or records
- ❑ Information about sexual assault/abuse
- ❑ Information about child abuse and neglect
- ❑ Domestic abuse of an adult with a disability

For office use only

Accepted ❑ Rejected ❑ ______________________________ Date informed: ____________________

Signature of Kids First Staff: ______________________________ Date: ____________________

Patient Name ______________________________ Patient Date of Birth ______________

The information for which I'm authorizing disclosure will be used for the following purpose:

- ☐ My personal use (*there is a fee for personal use copies*)
- ☐ Sharing with other health care providers; reason:
  - ☐ Moving (*please provide new address if not listed above*):
  - ☐ Appointment with specialist ☐ Age: Transferring care to adult provider ☐ Insurance Change
  - ☐ Dissatisfied with practice ______________________________
  - ☐ Other ______________________________
- ☐ Insurance Purposes
- ☐ Legal Purposes
- ☐ Other (*please specify*) ______________________________

Unless revoked, this authorization will expire 30 days from the date of signature on the authorization or from the date noted below. For mental health purposes this authorization will expire one year from the date of signature. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment; except, however, if my treatment is for the sole purpose of creating health information for disclosure to the recipient identified in the Authorization, in which case Kids First may refuse to treat me if I do not sign this Authorization. I understand that once Kids First discloses my health information to the recipient, Kids First cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and Illinois law governing the use and disclosure of my health information.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Kids First Pediatric Partners. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that Kids First may, directly or indirectly, receive remuneration from a third party in connection with the use and disclosure of my health information.

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act or the Confidentiality of Alcohol and Drug Abuse Patient Records Act information may not be re-disclosed unless the person who authorized this disclosure specifically authorizes the re-disclosure.

I understand that I have the right to inspect and obtain a copy of any information about mental health, drug and alcohol, or developmental disability services that is disclosed pursuant to this Authorization.

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Kids First Pediatric Partners to use or disclose my health information in the manner described above.

Printed Name of Patient or Legal Guardian: ______________________________
If Legal Guardian, Relationship to Patient: ______________________________
Signature of Patient or Legal Guardian: ______________________ **Date:** ______________

Authorizations including highly confidential items (*please see first page*) must be signed by the patient 12 and older.
Signature of Patient 12 or older: ______________________ **Date:** ______________

Authorizations including behavioral or mental health information and/or records must be witnessed.
Printed name of witness: ______________________________
Signature of witness: ______________________ **Date:** ______________

This authorization will expire:
Date (mm/dd/yyyy) ______________ *(If not specified, this release will expire 30 days of the date of the signature.)*