KIDS FIRST PEDIATRIC PARTNERS
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 Releases of Patient Health Information

Patient Name:	**Patient Date of Birth:**
Address:	
City / State / Zip:	
Telephone:	**Email:**

I authorize release of the following protected health information as follows:

To ☐ **From** ☐	**To** ☐ **From** ☐
Person / Institution:	**Person / Institution:** Kids First Pediatric Partners
Address:	**Address:** 4709 Golf Rd., Ste. 900
City:	**City:** Skokie
State / Zip:	**State / Zip:** Illinois, 60076
Telephone #: **Fax #:**	**Telephone #:** 847-676-5394 **Fax #:** 847-679-7183

Method of Record delivery, choose 1 option:

- ☐ MyChart
- ☐ Mail *(USPS to recipient listed above)*
- ☐ Pick Up
- ☐ Fax (*Please provide fax number*):

Information will be used for the following purpose:

Not Transferring Out of Practice (please specify):	***Transferring Out of Practice (please specify):***
☐ My personal use ☐ Sharing with other health care providers ☐ Legal purposes	☐ Moving ☐ Aged-Out ☐ Insurance ☐ Dissatisfied
☐ Other *(please specify)*	

Select the type of information to be used or disclosed:

☐ Pediatric Record Release: Visit notes, consultation reports, lab reports, test results, complete vaccine records, growth charts, medication list and a health history summary.

This Pediatric Record Release will contain records from the last one year of visit notes unless otherwise specified here:

From: _____ To: _____

If not Pediatric Record Release, then choose from below:

- ☐ Vaccination Record and Growth Chart
- ☐ Permission to speak with: _____
- ☐ Entire Medical Record

  Specify Date Range From: _____ *To:* _____
- ☐ Other *(please specify)*: _____

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Special Consent:

Certain types of highly sensitive information require a special permission from you, in order for us to release that information. Special consent is also required by adolescent patients aged 12-17 years old. Records may be reviewed by the provider prior to release. Providers have the right to deny release if deemed appropriate and in compliance with the law. The legal guardian or patient must check each item below for release, and the legal guardian and patient 12-17 must sign at the end of the form:

Check	Type of Information
	HIV/AIDS related health information and/or records
	Sexually Transmitted Illness information and/or records
	Sexual Assault/Abuse
	Birth Control information and/or records
	Pregnancy information and/or records
	Child Abuse/Neglect
	Behavioral and Mental health information and/or records
	Drug/alcohol use information and/or records
	Confidential Communication Note
	Substance Use Treatment information

I understand and agree with the following:

- This release will expire within six (6) months of the date of the 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, if my treatment is for the sole purpose of creating health information for disclosure to the recipient identified in the Authorization. In this case Kids First Pediatric Partners may refuse to treat me if I do not sign this Authorization.
- Once the organization or person authorized to receive this information has received it, the information may be re-released by that organization or person. If this is the case, the information may no longer be protected by federal privacy laws; however, Illinois law does not allow the re-release of AIDS/HIV, genetic testing, mental health and developmental disabilities information by the receivers of the information except in precise situations allowed by law. Also the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the Confidentiality of Alcohol and Drug Abuse Patient Records Act, and the Federal Confidentiality Rules, 42 C.F.R. Part 2, prohibit making any further disclosure of substance use disorder information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the regulation. All disclosures of substance use disorder treatment information are accompanied by a "*Notice to Individuals Receiving Alcohol, Drug Abuse and/or Mental Health Information*," included below.

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- I understand that I have the right to revoke (take back) this authorization at any time, I understand that if I wish to revoke this authorization, I must contact Kids First Pediatric Partners to do so. 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 Pediatric Partners may, directly, or indirectly, receive remuneration from a third party in connection with the use and disclosure of my health information.
- 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 the 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 18 or over or Legal Guardian	Relationship
Signature of Patient 18 or over or Legal Guardian	Date
Signature of Patient 12 or over	Date
Witness *(Mental health releases must be witnessed)* *(Anyone other than parent or patient may witness)*	Date
Interpreter (as applicable)	Date

Notice to Individuals Receiving Substance Use (Alcohol, Drug Abuse) and.or Mental Health Information: The confidentiality of alcohol and drug abuse patient records and/or mental health records disclosed to you pursuant to this authorization is protected by Federal law and regulations and by the Illinois Mental Health and Developmental Disabilities Confidentiality Act. Generally, you may not further disclose the identity of the patient, or any information identifying the patient as an alcohol or drug abuser, or recipient of mental health services, unless: (a) the patient consents in writing; (b) the disclosure is allowed by a court order; or (c) the disclosure is made to medical personnel in an emergency care situation or to qualified personnel for research, audit, or program evaluation purposes. Violation of Federal laws or regulations is a crime.

For Office Staff Only:

Signature of Kids First Pediatric Partners' Staff	Date

(Kids First Pediatric Partners' Staff has checked the identification of the signer and ensured that this is the legal representative who has rights of access)