Chicago PEDIATRIC CLINIC

1916 W. Irving Park Rd.
Chicago, IL 60613
(773) 477-4900
(773) 477-1510 - fax

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient(s):

_____ D.O.B. _____ _____ D.O.B. _____

_____ D.O.B. _____ _____ D.O.B. _____

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

FROM: _____
_____ Phone #: _____
_____ FAX #: _____

TO: _____*Chicago Pediatric Clinic*_____
_____*1916 W. Irving Park Rd.*_____ Phone #: ____*(773) 477-4900*_____
_____*Chicago, IL 60613*_____ FAX#: _____*(773) 477-1510*_____

Purpose or need for information: *Care of patient*

Disclosure will include: (check all that apply)

- ☐ **Immunization Record**
- ☐ **History & Physical Findings**
- ☐ **Consultation Reports**
- ☐ **Laboratory/X-Ray Reports**
- ☐ **Hospital Records**
- ☐ **Other _____**

Records for the Period (dates) from _____ to _____

I understand that the information to be released may include: (initial all that apply)

___ 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.

_____ _____
Signature of Parent/Legal guardian Witness

Date: _____