

LAKEVIEW PEDIATRICS, LLC

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Medical Records Release Authorization form

PATIENT'S NAME _____ D.O.B. ____/____/____

PARENT/GUARDIAN _____
(Relationship) (Phone #)

I hereby give _____ (name of doctor or facility) permission to release all records as indicated below, to _____ (name of doctor or facility, or self).

Release Records to the following Person(s) or Organizations:
Name: _____
Address: _____
Phone: _____
Email: _____

These records will be released for the purpose of:
 Patient Care Specialist Attorney/Client Insurance
 School Changing Practices Moving
 Personal Use Other: _____

The records to be released will include (please check only one of the following two options):

- Entire Medical Record **including** diagnoses and treatment of behavioral and/or mental health, HIV/AIDS related health information, pregnancy records, drug/alcohol diagnosis, treatment, and/or referral information, information about sexually transmitted disease, and birth control records.
- Please release only the following:**

<input type="checkbox"/> Immunization Records	<input type="checkbox"/> Behavioral and/or mental health records
<input type="checkbox"/> Growth Charts	<input type="checkbox"/> Drug/alcohol diagnosis, treatment, and/or referral information
<input type="checkbox"/> Medication List	<input type="checkbox"/> HIV/AIDS related health information and/or records
<input type="checkbox"/> Lab Results	<input type="checkbox"/> Information about sexually transmitted disease
<input type="checkbox"/> Imaging Results	<input type="checkbox"/> Pregnancy records
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Birth control records

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.

I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of healthcare is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that this authorization is valid for one full year unless a written letter of termination is received.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such revocation, the Authorization for Release of Confidential Health Information will terminate on (date) ____/____/____.

I understand that there is a fee per chart for these records and will pay at the time of the request. I also understand that once the medical records are released for the purpose of switching physicians or seeking other medical care, that I am only able to receive emergent care from Lakeview Pediatrics for 30 days and I am responsible for seeking medical treatment elsewhere thereafter.

Signature of Parent/Legal Guardian Relationship _____ Date ____/____/____

If this patient is 12 years old or older, the patient must also sign below to authorize the release of this information.

Patient Signature (If 12 years or older) Date ____/____/____

For office use only

Received: ____/____/____ Paid: ____/____/____ Approved: ____/____/____
Entered: ____/____/____ Paid amount: _____ Confirmation receipt: ____/____/____
Mailed: ____/____/____ Balance/records\$ ____/____ Upcoming appt/fax/address validated ____/____/____