New Beginnings Pediatrics, SC
2800 Keslinger Road, Suite 160
Geneva, Illinois 60134
Telephone: 630-232-7200
Fax: 630-232-2288

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________________ Date of Birth: ___________________________

Previous Name: ______________________________ Cell Phone: _____________________________

I request and authorize New Beginnings Pediatrics, SC to release healthcare information of the patient named above to:

Name:_______________________________________ Relationship: ____________________________

Address: _____________________________________ Telephone: ______________________________

City: ____ State: __________ Zip Code: ______________

This request and authorization applies to:

□ Healthcare information relating to the following treatment, condition, or dates: ________________

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All healthcare information

□ Other: ____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancrold, lymphogranuloma venereuem, HIV (Human Immunodefieciency Virus), AIDS (acquired Immunodefiency Syndrome), and gonorrhea.

□ Yes □ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

□ Yes □ No I authorize the release of any records regarding drug, alcohol, or mental health Treatment to the person(s) listed above.

Patient Signature: _________________________________ Date Signed: ________________________

This Release expires ____________________________ or one year from the date signed. Patient has the right to revoke or revise at anytime.