New Beginnings Pediatrics Fax (630)232-2288

PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. I authorize _____ to use or disclose the following information from my health records.

- ❑ My entire medical/health record.
- ❑ My medical/health records dated from _____to_____
- ❑ My protected health information relating to _____
- ❑ Other (please explain)_____

2. The information described above will be disclosed to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

3. The information will be disclosed for the purpose of:

- ❑ At the request of the individual
- ❑ Permission to return to work, sick note or medical excuse
- ❑ Research study: _____
- ❑ Insurance enrollment
- ❑ Insurance claim
- ❑ Employment purpose: _____
- ❑ Marketing: _____
- ❑ Other: _____

My authorization for disclosure of the information above expires;

- ❑ On _____
- ❑ Specify event: _____
- ❑ End of research

4. I understand that if the person or entity receiving my health information is not a health care provider or a health plan covered by federal privacy laws, my health information to be disclosed, as described above, may no longer be protected by these laws and may be re-disclosed.
5. I understand that I may refuse to sign this authorization form and that my refusal to sign this form will not affect my ability to obtain treatment or payment, or my eligibility for benefits. If the protected health information requested is to be used or disclosed for determining my eligibility for a health plan, my refusal to sign this authorization form may result in a denial of my application for benefits under the health plan.
6. I understand that I have the right to inspect or copy any of the information disclosed by this authorization.

7. I understand that I have the right to revoke this authorization at any time, in writing, except to the extent that _____has already acted in reliance upon this authorization as shown by my signature below and as explained in the Notice of Privacy Practices.
8. I understand that _____ and its employees are released from any legal responsibility or liability for disclosure of my protected health information as described above and as authorized by my signature below.
9. I understand that I will receive a copy of the signed authorization form.

Print Name of Patient/Legal Representative

Signature

Date

Reason for leaving Practice:

- Move
- Insurance Change
- Hours
- Staff issue
- Provider issue
- Other:_____

There will be a $10.00 fee per patient for copying records. Payment is required before processing request.
Please initial understanding of above statement
_____Initials

Patient Name: Patient Date of Birth:

1.

2.

3.

4.

5.

6.

7.

8.