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CONSENT TO RELEASE INFORMATION

Patient Name: _____ Date of Birth: _____ Phone:_____

INFORMATION TO BE RELEASED FROM:

Name/Agency: _____

Address: _____

City/State/Zip: _____

Phone: _____ __ Fax: _____

SEND REQUESTED INFORMATION TO:

Name/Agency: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

CHECK INFORMATION NEEDED:

- o Immunizations
- o Consults/Referrals
- o Lab Reports
- o Other: _____
- o Progress Reports

I authorize the release of confidential information relating to (check all that apply):

- o Mental Health Treatment Records
- o
- o Substance abuse (alcohol/drug use)
- o Other: _____
- o HIV/AIDS related information

ILLINOIS ONLY: Minor's signature required if ages 12-17 for mental health records.
PLEASE LIST ANY INFORMATION NOT TO BE RELEASED:

_____

THIS INFORMATION IS REQUIRED FOR:

- o Transfer of Care REASON:_____
- o Personal Copy
- o Consultation/Referral

HOW WOULD YOU LIKE TO RECEIVE YOUR RECORDS:

- o Pick-up in clinic
- o Mail to individual/agency listed

I give permission to release my information I've selected on this form to the individual(s) or agency(s) I've named and only for the purpose that I've checked. I have the right to view my medical records. Copies of my records may be obtained with reasonable notice with my written authorization. I understand that Pediatric Group Associates has up to 30 days to release the information requested. I understand that if I am transferring care Pediatric Group will continue to see me for 30 days after my information is released.

PATIENT SIGNATURE: _____ DATE: _____

SIGNATURE OF REPRESENTATIVE: _____ DATE: _____

RELATIONSHIP TO INDIVIDUAL: _____