# AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

CHILD AND ADOLESCENT HEALTH ASSOCIATES
1030 N CLARK ST, 4TH FLOOR, CHICAGO, IL 60610

Patient name_____ Date of birth _____
Address _____ City/State/Zip_____
Telephone _____

**I hereby authorize the protected health information regarding the above-named person be forwarded:**
**To: (Recipient)**
Person/Institution _____
Address _____
City/State/Zip _____
Phone: _____ Fax: _____

**From:**
Person/Institution ____Child and Adolescent Health Associates_____
Address _____1030 N Clark St, 4th floor_____
City/State/Zip ____Chicago, IL, 60610_____
Phone: ____312-943-6964_____ Fax: _____312-943-6924_____

**I authorize the release of information covering the period(s) of healthcare from**
Date(s)_____ To dates(s) _____

**The type of information to be used or disclosed is as follows:**
_ History and physical examination _Discharge summary _Abstract (summary of health hx)
_Consultation reports _Operative reports _Diagnostic tests (labs, xrays, etc)
_Progress notes _Verbal only
_Other (please specify) _____

**This information for which I am authorizing disclosure will be used for the following purpose:**
_My personal use (there is a fee for personal use copies)
_Sharing with other health care providers (no charge if sent directly to the provider-address must be provided as recipient above)
_Other (please specify) _____

**This authorization will expire:**
Date _____, 20____. If not otherwise specified this release will expire within 30 days of the date of signature.

I understand that Child and Adolescent Health Associates may, directly or indirectly, receive remuneration from a third party in connection with the use and disclosure of my health information. I understand that I have the right to inspect and obtain a copy of any information about mental health, drug and alcohol, or developmental disability services that is disclosed pursuant to this Authorization. I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Child and Adolescent Health Associates to use or disclose my health information in the manner described above.

**Printed name of Patient or Legal Guardian:** _____
**Signature of Patient or Legal Guardian:** _____
**Date:** _____