

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 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

From:

Person/Institution _____
Address _____
City/State/Zip _____
Phone: _____ Fax: _____

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: _____