**Summers Pediatrics, S. C.**

**2010 South Arlington Heights Road Suite 210**

**Arlington Heights, IL 60005**

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**AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTHCARE INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby **authorize Summers Pediatrics, S.C.** to release to:

**(Name of Patient or Authorized Agent)**

**(Name of Health Care Facility, Physician, Agency, etc.)**

the following information contained in the patient record of born

**(Patient’s Name) (Birthdate)**

\_\_\_\_The entire medical record, excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/AIDS records-May include a transfer charge.

\_\_\_\_Mental Health Treatment Records

\_\_\_\_Alcoholism/ Drug Abuse Treatment Records

\_\_\_\_HIV/Acquired Immune Deficiency Syndrome (AIDS) Records

\_\_\_\_Laboratory Reports

\_\_\_\_X-ray Reports

\_\_\_\_Operative Notes

\_\_\_\_Immunization Record

\_\_\_\_Other:

The above information for the following period of time shall be released:

From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Date) (Date)**

The purpose(s) of the authorization is (are) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above described information, I understand that it will not be disclosed, except as provided by law.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I, also, understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information.

Written revocation must be sent to the physician’s office. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on \_\_\_\_\_\_\_\_\_\_\_\_\_.

Signed: Date: \_\_\_\_\_

If not the patient, please specify your relationship to patient: \_\_\_\_\_.