Right Start
Pediatric Therapies, Inc.

RightStartPediatrics.com | 600 S Washington St Ste 105 Naperville IL 60540

Authorization to Release Protected Health Information

Patient Name: _____ Birthdate: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Social Security # : (optional) _____ Phone #: _____

Medical Record #: _____ Account #: _____ ☐ Mail ☐ Call for pickup

I authorize the disclosure of the above named individual's Protected Health Information (PHI) and request:

Name: _____

Address: _____

to release the requested information to:

Name: _____

Address: _____

The purpose for this requested information is:

☐ Healthcare provider ☐ Personal use ☐ Attorney ☐ Insurance

☐ Other, specify: _____

Date(s) of services requested:_____

The following information is requested:

☐ PHI pertinent for continuing healthcare or personal health records. Includes: Face Sheet, Emergency Record, H&P, Consult Report, Operative Report, Discharge Summary, Lab & Radiology Reports, EKG, EEG, Other Diagnostic Test Reports, Discharge Instructions

☐ Anesthesia records
☐ Autopsy report
☐ Billing records
☐ Conditions/Consent of Admission
☐ Consent forms
☐ Images / xrays / scans
☐ Immunization records

☐ Medication records
☐ Nurses notes
☐ Occupational Therapy Notes
☐ Photographs
☐ Physical Therapy Notes
☐ Physician Orders
☐ Physician Progress Notes
☐ Speech Therapy Notes

☐ Other, specify: _____

Some conditions may not apply to our young pediatric patients and may apply to our adolescent pediatric patients. I acknowledge, and hereby consent to such, that the released information may contain alcohol or drug abuse, psychiatric, HIV or AIDS, sexually transmitted disease, or genetic testing content. _____(Initials)

I understand that:

1. Authorizing this release of information is voluntary and I may refuse to sign this authorization.
2. My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this authorization.
3. I may revoke this authorization, in writing, at any time, except to the extent that action has been taken in reliance upon it.
4. The information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy regulations.
5. I may receive a copy of this authorization.

_____ _____

Signature of Patient or Patient's Legal Representative **Today's Date**

_____ _____

Print Name of Legal Representative (if applicable) **Relationship to Patient (if not the Patient)**

Note: Guardians and Durable Power of Attorney designees should include a copy of the applicable paperwork