Kids First Pediatrics, Ltd.
Authorization to Release Medical Information

1. I AUTHORIZE:

_____
Name of sending person/organization

_____
Street Address

_____
City State Zip Code

2. TO RELEASE TO:

Kids First Pediatrics, Ltd.
24600 West 127th Street
Building B, Suite 345
Plainfield, IL 60585
(815) 609-KIDS (5437)
(815) 609-8111 (Fax)

3. **NAME OF CHILD OR DEPENDENT:**_____

4. **DATE OF BIRTH OF CHILD OR DEPENDENT**:_____

5. **INFORMATION TO BE RELEASED:** (Check all applicable)
☐ All Information ☐ Immunization Records ONLY ☐ All Progress Notes ☐ Lab Reports
☐ X-ray Reports ☐ Allergy Records ☐ Consultant Letters ☐ Other:_____

SPECIAL AUTHORIZATION: Check applicable box(es) and sign immediately below.
By signing below, I am authorizing the office to release any and all information regarding:
☐ Alcohol ☐ Drugs ☐ Mental Health ☐ Sexually Transmitted Diseases ☐ HIV ☐ AIDS

Note: If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature (IF OVER 18 YEARS OLD): _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

6. **RECORDS FROM THE TIME PERIOD:** _____/ _____ / _____ through _____ /_____/_____

7. **PURPOSE OF DISCLOSURE:** (Check applicable purpose)
☐ Transfer of Medical Care ☐ Personal ☐ For Other Medical Provider
☐ Personal ☐ ☐ Other: _____

8. I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

9. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

10. The requestor may be provided with a copy of this authorization.

Patient's Signature (if over 18 years old):_____ Date: _____

Parent or Guardian's Signature: _____ Date: _____

Date of Birth: _____ Home Phone: _____ Work Phone: _____

For office use only:_____
MR# Date Initials of Staff Member