Fox River Pediatrics

When it comes to your child's health, we care

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AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME: _____ DOB: _____

STREET ADDRESS: _____ PHONE: _____

PERMISSION IS HEREBY GRANTED FOR RELEASE OF MEDICAL INFORMATION FROM:

Previous Physician: _____

Address of Facility: _____

Phone: _____ Fax: _____

Fax to: Fox River Pediatrics 630-553-3405

*(please fax only **30 pages or less**, more than 30 pages, please mail to above address)*

Information to be disclosed:

- ☐ The entire medical records
- ☐ Laboratory/Radiology reports only.
- ☐ Immunization records only.
- ☐ Other: _____

I understand that I have the right to inspect the information I have authorized to be released. In the event that 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 the practice may not condition treatment on whether I sign the authorization, except when the provision of healthcare is solely for the purpose of creating protected health information disclosure to a third party.
I understand that this authorization is valid until it expires, unless revoked before that time.
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(s) have already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such revocation, this Authorization for Release of Medical Records will terminate 90 days from the date of signature. Governor Ryan signed into law Bill 721 setting amounts for copying medical records. Copy fees are according to recognized guidelines.

Signature of Parent: _____ Date: _____