Transfer In Form

Patient Authorization for Release of Protected Health Information

_____ _____

(Child's Last Name) (First Name)

_____/_____/_____ (_____)_____-_____

(Date of Birth) (Telephone Number)

Previous Physician's Name:_____

Address:_____

Phone / Fax:_____

I request the following information to be disclosed to: **Northwest Suburban Pediatrics, S.C.**
455 S. Roselle Rd. Suite 209
Schaumburg, IL 60193
Phone: 847-352-9910 / Fax: 847-352-4471

- oPhysician Visit Notes_____
- oLab Reports_____
- oImmunizations _____
- oX-ray Reports_____
- oComplete Chart_____
- oOther_____

(Please check the appropriate box and include specific dates if necessary)

_____ _____

(Patient Signature or legal guardian) **(Date)**

I understand that this information disclosed could contain mental health, genetic testing, developmental disabilities, alcohol and drug abuse, and/or Acquired Immune Deficiency Syndrome (AIDS/HIV) information. I understand that I have the right to inspect and /or obtain a copy, (for the appropriate fee) of the information prior to disclosure. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I may revoke this authorization at any time (except to the extent that action has already been taken) by submitting a written revocation to the Privacy Officer of Wee Care Pediatrics at the office address. This authorization will expire 90 days from today's date.

_____ _____

Reviewed by: (initials / date) **Processed by: (initials / date)**