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.**
3335 N. Arlington Hts. Rd. Ste. C
Arlington Heights, IL 60004
Phone: 847-788-8300 / Fax: 847-788-8306

- 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)**