1015 Summit Street
Elgin, IL 60120

Associates in Pediatrics, S.C.
1020 E. Schaumbrug Road
Streamwood, IL 60107

1530 N Randall Road
Elgin, IL 60123

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164

Authorization

☐ Yes. I authorize Associates in Pediatrics, S.C. to use and disclose the protected health information described below to ____ (Parent or Guardian).

Effective Period

This authorization for release of information covers the period of healthcare from the following dates:

____________ to ____________ **Or** ☐ ALL past, present, and future periods.

Extent of Authorization (how much information are you ok with us releasing?)

A. ☐ Yes. I authorize the release of ALL my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

B. ☐ Yes. I authorize the release of my complete health record **EXCEPT** for the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): ____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until ________________ (date or event), at which time this authorization expires.

IF YOU DO NOT WANT ANY INFORMATION RELEASED PLEASE SELECT THIS OPTION BELOW

C. ☐ **NO.** I DO NOT WANT ANY INFORMATION RELEASED TO A PARENT OR GUARDIAN.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____ ____________

Signature of patient Date

____ ____________

Printed name of patient Date