Kids Health Partners, LLC
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Authorization for Release of Patient Health Information

Patient Name:	Date of Birth:
Address:	
Phone	Alternate Phone:

I hereby authorize the protected health information regarding the above-named person to be exchanged between:

From:	
Person/Institution:	
Address:	
City	
State/Zip:	

To:	
Person/Institution:	
Address:	
City	
State/Zip:	

Please send using the following method:

□ Fax (number)	□ Certified Mail	□ I will pick up
□ Standard, Unencrypted Email: _____ *(Requires review and signature of the Email Security Risk Disclaimer on Page 2)*		

I authorize the release of information covering the period(s) of healthcare: From Date: _____ To Date: _____
The type of information to be used or disclosed is as follows:

□ Immunizations, growth charts, and problem list		
□ History and physical examination	□ Discharge summaries	□ Diagnostic reports (labs, etc)
□ Consultation reports	□ Operative reports	□ Verbal only (Please specify):
□ Progress notes	□ X-ray reports	
□ Other (Please specify):		

The following highly confidential items must be checked to be included in the use and disclosure of other health information:

□ HIV/AIDS related health information and/or records (the patient 12 or over must authorize this release)	
□ Behavioral or mental health information and/or records (release must be witnessed and the patient 12 or over must authorize this release)	
□ Information about sexually transmitted diseases (the patient 12 or over must authorize this release)	
□ Pregnancy (the patient 12 or over must authorize this release)	
□ Birth control (the patient 12 or over must authorize this release)	
□ Drug/alcohol diagnosis, treatment, and/or referral information (the patient 12 or over must authorize this release)	
□ Genetic testing information and/or records	□ Information about sexual assault/abuse
□ Information about child abuse and neglect	□ Domestic abuse of an adult with a disability

This information for which I am authorizing disclosure will be used for the following purpose:

□ My personal use	□ Other (Please specify):
□ Sharing with other health care providers	

Turn Over

Acknowledge in the checkboxes below:

- □ I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment; except, however, if my treatment is for the sole purpose of creating health information for disclosure to the recipient identified in the Authorization, in which case Kids Health Partners, LLC may refuse to treat me if I do not sign this Authorization.
- □ I understand that once Kids Health Partners discloses my health information to the recipient, Kids Health Partners cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and Illinois law governing the use and disclosure of my health information.
- □ I understand that I have the right to revoke this Authorization at any time. I understand that if I revoke this Authorization, I must do so in writing and present my written revocation to Kids Health Partners. I understand that the revocation will not apply to information that has already been released in response to this Authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- □ I understand that Kids Health Partners may, directly or indirectly, receive remuneration from a third party in connection with the use and disclosure of my health information.
- □ Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act or the Confidentiality of Alcohol and Drug Abuse Patient Records Act information may not be re-disclosed unless the person who authorized this disclosure specifically authorizes the re-disclosure.
  I understand that I have the right to inspect and obtain a copy of any information about mental health, drug and alcohol, or developmental disability services that is disclosed pursuant to this Authorization.
- □ **UNENCRYPTED EMAIL SECURITY DISCLAIMER AND WARNING:** By checking the "Standard Email" box on Page 1 and signing below, I explicitly request that Kids Health Partners, LLC transmit my child's or my protected health information via unencrypted email.
  I understand and accept the following security risks:
  1. Standard email is not a secure, encrypted, or confidential method of communication.
  2. Information sent via unencrypted email is at risk of being intercepted, read, or modified by unauthorized third parties during transit.
  3. Kids Health Partners, LLC cannot guarantee the privacy or security of the records once the email leaves its internal network servers.

  I certify that I have been informed of these specific risks and the available secure delivery alternatives (such as fax, certified mail, or in-person pickup). I knowingly and voluntarily authorize Kids Health Partners, LLC to send the records via standard, unencrypted email.
  I have read and understand the terms of this authorization, and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Kids Health Partners to use or disclose my health information in the manner described above.

Printed Name of Patient or Legal Guardian: _____

Signature of Patient or Legal Guardian: _____ Date: _____

If signed by Legal Guardian, please specify your relationship to the patient: _____

For information regarding Mental Health, HIV/AIDS, Drug and Alcohol, Sexually Transmitted Diseases, Pregnancy and Birth Control, the patient 12 or over must sign to release these records.
Signature of Patient 12 or over: _____ Date: _____

For Mental Health Releases Only (Mental health releases must be witnessed):

Witness Signature: _____ Date: _____

This authorization will expire on _____, 20____. *If not otherwise specified, this release will expire 30 days after the signature date.*