REDBIRD pediatrics PLLC
Exceptional care to help your kids take flight

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Authorization for Release of Health Information

Patient Name: _____
Last First MI

Date of Birth: _____ Social Security Number: _____ -- _____ -- _____
MM/DD/YYYY

I authorize and request: _____
Name of Physician or Medical Facility

_____
Street Address

_____
City State Zip

To release to: ☐ Redbird Pediatrics, PLLC
793 Sunset Blvd.
O'Fallon, IL 62269

or

_____
Name of Physician or Medical Facility

_____
Street Address

_____
City State Zip

What should be released:
- ☐ Complete medical records
- ☐ Medical records for the period from _____ to _____
- ☐ Immunization records only

Disclosure of confidential information: (Please check all that apply)
- ☐ I consent to the disclosure of medical information that may include chemical or alcohol dependence or psychiatric care including Attention Deficit Hyperactivity Disorder (ADHD).
- ☐ I consent to the disclosure of medical information that may include blood tests that have been done to detect antibodies to or levels of HIV which is the probable cause of Acquired Immune Deficiency Syndrome (AIDS).

Requested medical information is needed for:
- ☐ Transfer of care to Redbird Pediatrics, PLLC
- ☐ Other: _____

I understand that my medical records or the medical record of the patient for whom I am signing may include alcohol/drug abuse, psychiatric treatment or HIV/AIDS testing or treatment and are covered by Federal Regulations and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I also understand that I may revoke this consent at anytime except to the extent that prior action has been taken on it. In any event, this consent will expire on _____ or ninety (90) days from the date the authorization is signed. I understand that any fees assessed for copying records of the PHI (as determined by Illinois Public Act 92-228) are my responsibility. **Redbird Pediatrics, PLLC,** its employees, officers and physicians are hereby released from all legal liability or responsibility for the release of the records to the extent indicated and authorized herein.

_____ _____ _____
Patient Signature or Legal Representative Relationship to Patient Date

_____ _____
Witnessed By Date