

## Patient Authorization for Release of Protected Health Information

\_\_\_\_\_  
 (Patient Name):      (Last Name)                      (First Name)                      (Social Security Number)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 (Date of Birth)                      (\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_  
 (Telephone Number)

<p><b>I, hereby request and authorize:</b></p> <p>_____                  (Name of individual or agency disclosing the information)</p> <p>_____                  (Mailing address of individual or agency)</p> <p>_____                  (Telephone/fax number of individual or agency)</p>	<p><b>To disclose the information identified below to the individual or agency listed below:</b></p> <p style="text-align: center;"><b>Dr. Joanna E. Betancourt MD., FAAP</b></p> <p>_____                  (Name of individual or agency receiving the information)</p> <p style="text-align: center;"><b>600 S. Randall Rd. Suite 220</b></p> <p>_____                  (mailing address of individual or agency)</p> <p style="text-align: center;"><b>Algonquin, IL 60102</b></p> <p>_____                  (Telephone/fax number of individual or agency)</p> <p style="text-align: center;">847-854-9402 / 847-854-9403 (fax)</p>
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***I request the following information to be disclosed :(please check the appropriate box include dates)***

- Physician Visit Notes \_\_\_\_\_
- Lab reports \_\_\_\_\_
- Immunizations \_\_\_\_\_
- X-ray reports \_\_\_\_\_
- Other: \_\_\_\_\_

Purpose for release of PHI: \_\_\_\_\_

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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 redisclosure 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 Salud Pediatrics, S.C. at the office address. This authorization will expire on \_\_\_\_\_.

*(Expiration date or defined event)*

\_\_\_\_\_  
 (Patient Signature (or legal guardian)                      (Date)

**Method of Disclosure:**       Mail       Hand carry       Verbal       Fax       charge       no charge

\_\_\_\_\_  
 (Witnessed by/Date)                      (Processed by/Date)