BLOOMINGTON PEDIATRICS, LTD.
306 ST. JOSEPH DR.
BLOOMINGTON, IL 61701
TEL (309) 662-0504
FAX (309) 663-7645

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Street Address: _____

City, State, Zip: _____ Phone #: _____

I AUTHORIZE THE DISCLOSURE OF MY PERSONAL HEALTH INFORMATION AS FOLLOWS:

Party to RECEIVE my health information:

Name: _____

Address: _____

City, State, Zip: _____

Party to RELEASE my health information:

Name: _____

Address: _____

City, State, Zip: _____

Note: Bloomington Pediatrics is unable to send or accept records on CD.
Acceptable methods are paper, fax, secure email, or encrypted USB drive.

PURPOSE OF DISCLOSURE:

Moving to a new location: _____ Changing Insurance: _____ Other: _____
Specialist Referral: _____ Patient Request: _____ _____

DESCRIPTION OF MY HEALTH INFORMATION TO BE DISCLOSED:
Bloomington Pediatrics can only release documentation created by our facility, physicians, and staff.
Routine Records: _____ Complete Chart: _____
Specific Records Only: _____ Please specify: _____

This authorization is valid for 1 year unless I cancel this authorization in writing before it expires. The cancellation must be dated and signed. It must be delivered to Bloomington Pediatrics, 306 St. Joseph Dr., Bloomington, IL 61701.

I understand the health information disclosed by this authorization may be redisclosed by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

Signature: _____ Date: _____

Relationship if not patient: _____ WITNESS: _____