BLOOMINGTON PEDIATRICS & ALLERGY, 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: ____________________________

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 & Allergy 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 the Privacy Officer at Bloomington Pediatrics and Allergy, 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: ____________________