

A.B.C. PEDIATRICS, LTD.

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AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize ABC Pediatrics, Ltd. to use and/or disclose certain protected health information (PHI) about me to _____.

Name of entity to receive this information

This authorization permits ABC Pediatrics, Ltd. to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, types of services, level of detail to be released, origin of information, etc.). If requested by the patient, permission may be listed as “any and all information”:

The information will be used or disclosed for the following purpose:

If requested by the patient, purpose may be listed as “at the request of the individual.”

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.

(Expiration Date or Defined Event)

My written revocation must be submitted to the Privacy Officer at:

ABC Pediatrics, Ltd.
1247 Rickert Drive, Suite 101
Naperville, IL 60540

Signature of patient

Date

Print Name of patient