Authorization for Release of Information

Patient name: I would like: ☐ copy or ☐ view my records

I hereby authorize Chicago Pediatric Therapy & Wellness Center, LLC to release from my medical record as indicated below to:

Name:

Address:

City: State: Zip: Phone: Fax:

I authorize the additional person(s) to receive my protected health information:

- ☐ Family member's
- ☐ Other:

My authorization applies to the information described below: Only this information may be used and/or disclosed pursuant to this authorization:

- ☐ Treatment documents & information
- ☐ Billing records
- ☐ Photographs, videos, testimonials
- ☐ Other:

Purpose of Disclosure:

☐ Legal ☐ Insurance ☐ School ☐ Marketing ☐ Educational brochures/material

1. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been take in reliance upon it.
2. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal privacy regulations.
3. I understand that if I am being requested to release this information by Chicago Pediatric Therapy & Wellness Center, LLC for the purpose of:
   a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
   b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
   c. I have been informed that Chicago Pediatric Therapy & Wellness Center, LLC ☐ will ☐ will not receive financial or in kind compensation in exchange for disclosing the health information described above.
4. I understand that there may be a fee paid for copies. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.
5. I hereby give Chicago Pediatric Therapy & Wellness Center, LLC the right and permission to copyright and/or use publish and reuse photographic pictures and videos through any media and for whatever purpose Chicago Pediatric Therapy & Wellness Center, LLC chooses. I hereby waive the right to approve the finished photograph or video which might be used in conjunction with the finished product.
6. I have read the foregoing release, authorizations and agreement, before affixing my signature below and warrant that I fully understand the contents thereof:

PATIENT'S NAME

PARENT/LEGAL GUARDIAN *Date*

SIGNATURE OF WHO RECEIVED INFORMATION *Date Received*

FOR OFFICE USE ONLY Date Request Filled: By:	