siskin children's institute | CENTER FOR DEVELOPMENTAL PEDIATRICS

Authorization to Release/Obtain Medical Records

Patient's Name: ______________________________ Date of Birth: ____________

Patient's Address: ______________________________ Phone #: ____________

City/State/Zip: ______________________________ MRN #: ____________

I hereby authorize the release and/or request for my medical records as outlined below:

1. Provider/Facility Releasing Medical Records: ______________________________

   Address: ______________________________

   Phone #: ____________________ Fax #: ____________________

   Email Address: ______________________________

2. Provider/Facility Receiving Medical Records (if applicable): ______________________________

   Address: ______________________________

   Phone #: ____________________ Fax #: ____________________

   Email Address: ______________________________

3. **Dates Requested:** ____________________ **to** ____________________

4. **Specific Records to be Released/Obtained:**
   - ☐ All Medical Records
   - ☐ Medical Visit Notes
   - ☐ Therapy Records
     - ☐ Speech Therapy
     - ☐ Occupational Therapy
     - ☐ Physical Therapy
     - ☐ Feeding Therapy
   - ☐ ABA Therapy Records
   - ☐ Psychological Records
   - ☐ IEP
   - ☐ Labs

5. **Purpose of Request:**

   ☐ Continuation of Care ☐ Billing/Insurance ☐ SSA/Disability ☐ Legal Proceedings ☐ Other (Specify)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this form.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. If the recipient is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described in this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.
7. This authorization is valid for one year.

______________________________ ______________________________

Signature **Date**

______________________________ ______________________________

Printed Name **Patient's Name and Date of Birth**