Authorization To Release Information

Patient Name _____ Date of Birth_____

I hereby authorize Naperville Pediatric Associates to release Dr.Badowska's Medical Records to

_____
_____
_____

_____ All Medical Records including prior medical records if available (no limitation)
_____ All Medical Records except those related to the following conditions:
( ) mental health ( ) substance abuse, ( ) HIV/ AIDS
_____ All Medical Records except the following specified restriction(s):
_____

I understand that by making this request (1) Naperville Pediatric Associates, Ltd. (including its physicians and employees) is hereby released from any legal responsibility or liability for disclosure of this information. (2) Furthermore, I understand that this authorization will expire 1 year from the signed date unless I exercise my right at any time to revoke this consent in writing. (3) Furthermore, I understand I am required to pay a fee for the release of my records. I do not hold Naperville Pediatric Associates liable to the extent that action has been taken in reliance of this document.

( ) I wish to pick up the records myself.
( ) I wish to have you mail the records to the address listed above.

Parent/ Legal Guardian Signature _____ Date _____

Witness to above signing _____ Date _____

Payment can be made by credit card, check or cash. **Every effort will be made to honor this request within 2 weeks of our receiving it along with the appropriate fee.**

For Office Use Only

Received:	Mailed	Doctor	Office
Completed	Picked up	Privacy Officer	

This form was last revised on June 2014 by Naperville Pediatric Associates