BRIGHT HORIZONS
PEDIATRICS, P.C.

Patient Authorization to Release \ Protected Health Information

Note: This form must be completed by a parent or guardian for minors. Patients 18 years of age or older are required to complete and sign their own release form.

1. Patient Name(s): **Date(s) of Birth:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

2. Release of information
Circle: TO FROM

Bright Horizons Pediatrics, P.C.

1790 Nations Drive Suite #207

Gurnee, IL 60031

3. Release of information
Circle: TO FROM

_____
Name of Physician/Health Care Facility

_____
Street Address

_____
City/State/Zip

____ **Requested Records will be picked up at the office**

4. Heath Information (if to be Released from BHPeds)

_____ Immunizations & Growth Record (no charge)
_____ Full Records $0.50 per page (Maximum charge of $50 per family)

5. Reason for your request

_____ school/camp _____ moving _____ change of insurance _____ patient transfer

6. Signature

- I authorize the use and/or release of my protected health information as described in paragraph four.
- I understand that this authorization is voluntary and I have had full opportunity to review all contents.
- I understand that the information used or release as a result of this authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without my authorization.

Signature of patient, parent or guardian: **Relationship to patient(s):**

_____ _____

Print name: **Date:**

_____ _____