Mundelein Pediatrics, S. C.
Pediatrics - Adolescents
1170 E. Belvidere Road • Suite #106
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HIPAA Release Form
Acknowledgment & Authorization Form

Patient Name ______________________________ DOB ______________

Notice of Privacy Practices

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of the Notice will be provided upon request or available to me on our website. We may use your protected health information (PHI) for the following:

- Treatment: your protected health information may be used or disclosed by those who are involved in your care.
- Payment: we may use and disclose PHI so that we can receive payment for the treatment services provided to you.
- Required by law: your PHI will be used or shared as required and allowed by law.

Phone Message and Contact Authorization

Do the physicians and staff of Mundelein Pediatrics have your permission to:

[ ] Leave a message with detailed information
[ ] Leave a message with a call back number

Authorized Individuals

I give authorization to the doctors and staff of Mundelein Pediatrics to discuss my child's protected health information and financial information with the following people

*Please list yourself as well as anyone else we may contact.

Name	Relationship to patient	Phone Number

X ____

Signature of Patient (If 18 years or older), Parent or Guardian   Print Name   Date

Please Continue on Back →

Phone: (847) 548-PEDS (7337) Fax: (847) 548-9909