St. Clair PEDIATRICS

4941 Benchmark Centre Drive #100, Swansea, IL | Phone 618.624.9970 | Email customerservice@stcpeds.com

New Patients Release Form

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patients Name: _____ **Date of Birth:** _____
First Middle Last

I Hearby Authorize and Request: _____

Name of Physician or Medical Facility: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

To Release to: St. Clair Pediatrics, LLC 4941 Benchmark Centre Dr. Suite 100 Swansea, IL 62226

Medical Records covering the periods from _____ to _____.

Requested Medical Information is Needed for: _____

Reason for Transfer: _____

Medical Records May be Faxed to: 618-624-9973

I understand that my medical records or the medical record of the patient for whom I am signing may include Alcohol/Drug abuse, Psychiatric treatment or HIV/AIDS testing or treatment and are covered by Federal Regulations and cannot by disclosed without my written consent, unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that prior action has been taken on it. In any event, this consent will expire ninety (90) days from the date the authorization is signed. St. Clair Pediatrics, LLC, its employees, officers and physicians are hereby released from all legal liability or responsibility for the release of the records to the extent indicated and authorized herein.

Patient/Responsible Party Signature: _____

Relationship to Patient: _____ **Date:** _____