

RELEASE OF MEDICAL INFORMATION

All information contained in the medical record is confidential and protected under HIPAA. This form must be completed in full, signed and dated by the patient (over 18) or the guardian and returned to the office.

No charge will apply to copy vaccination records only. Medical record copying fees and shipping fees for all other records will apply. To view the Illinois State Comptrollers copying fees breakdown go to:
<https://illinoiscomptroller.gov/agencies/resource-library/statutorily-required/copying-fees-adjustments/>

PATIENT INFORMATION

Patient name _____ Date of Birth _____
Address _____
City _____ State _____ ZIP _____
Primary Phone _____ Alternate Phone _____

RELEASE FROM:

Doctor's Office: Jennifer Pyle, M.D.
Address: 1700 W Central Rd, Suite 200
City: Arlington Heights, IL 60005
Phone: (847) 392-1880 **Fax:** (847) 392-1980

RELEASE TO:

Doctor's Office or Name of Parent/Guardian

Address: _____
City _____ **State** _____ **Zip** _____

INFORMATION TO BE RELEASED:

_____ Full details of medical record
Or check specific records below
_____ Office visit notes
_____ Immunization Records
_____ Lab results (specify which results) _____
_____ X-ray reports (specify which reports) _____
_____ Hospital records (specify which records) _____

PURPOSE/NEED FOR INFORMATION:

_____ Taking records to other physician
_____ Moving
_____ Legal Purposes
_____ Insurance Purposes
_____ Other: _____

METHOD OF RELEASE:

_____ U.S. Mail
_____ Patient/Parent Pick-up

GUARDIAN OR PATIENT SIGNATURE

DATE

OFFICE USE ONLY

Information indicated above release on: _____

Office Staff signature: _____