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 _____

Address _____

City _____ State _____ ZIP _____

Primary Phone _____ Alternate Phone _____

RELEASE FROM:

Doctor's Office: Medical Pediatrics, Ltd.

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: _____