# North Arlington Pediatrics

1430 N. Arlington Heights Road, Suite 210
Arlington Heights, IL 60004
Phone: 847-253-3600 Fax: 847-253-3912

Authorization to Release or Obtain Medical Records and For Use or Disclosure of Protected Health Information

**Patients Name(s) including date of birth** (Patient 18 years of age must request their own records)
____________________ DOB _______________ _____________________ DOB ___________
____________________ DOB _______________ _____________________ DOB ___________

**The reason or purpose of this release of information are as follows:**
_____ Sharing information with another Health Care Provider (NOT A TRANSFER)
(Only the last five years will be released unless otherwise specified)
_____ North Arlington Pediatrics requesting information
Specific Information Needed: _________________________________________________________

_____ Personal Use _____Legal Reasons_____ Transfer of Care (Leaving the practice)
Other: _________________________

Reason for the transfer: ______ age _______ moving _______ insurance change ______ other
______ Dissatisfaction with practice

We would like to know the name of the new doctor and/or practice should we be contacted in the future:

Name: ______________________________________ Phone Number: ____________________________
Town and State:
_____________________________________________________________________________________
Do you give us permission to speak to your new doctor? YES NO ______Initial Here

1. I am aware that the medical records are privileged information and that my request and attested to by my signature that I waive this privilege and hold North Arlington Pediatrics, it's partners and staff, personally and corporately, harmless from any and all liability that might be associated with the release of this information. By signing below, I represent and warrant that I have authority to sign this document and authorize the use of disclosure of protected health information that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of protected health information. _______ (Initial Here).
2. I am aware that the release of my medical records could take up to 14 days to complete and that North Arlington Pediatric strongly recommends picking up the records. ____ (Initial Here)
3. I am aware that after two follow up phone calls that if these medical records are not picked up that North Arlington Pediatrics can shred the records prepared and that there may be a reasonable fee for the completion of records in the future. ______ (Initial Here)

_____ I authorize that someone other than the person filling out this request can pick up the records on my behalf.
_____ I authorize that only the person filling out this request can pick up the medical records.

Signature: ___________________________________________ Date: _____________
Phone Number to call once records are ready for pick up: ____________________________________________________

**If the patient is under 18 years of age, unless the Patient is an emancipated minor, this Authorization must be signed by a parent or guardian who has the authority to act on the minor-patients behave. By signing this form for someone else, you as the parent or guardian or legal representation have the legal authority to act on the patient's behalf and that you are not prohibited by Court Order from having access to requested medical records.**

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