North Arlington Pediatrics

1430 N Arlington Heights Rd. Suite 210

Arlington Heights, IL 60004

Phone: 847-253-3600 Fax: 847-253-3912

Email: inquiry@northarlingtonpediatrics.com

Authorization to release or obtain Medical Records for use of Disclosure of Protected Health Information

Patient name(s) including date of birth: (Patients 18 years of age must request their own records)

_____ DOB _____ DOB

_____ DOB _____ DOB

-The reason or purpose of this release of information is as follows:

☐ Moving; please provide new address: _____

☐ Insurance Change ☐ Age ☐ Dissatisfaction with Practice ☐ Legal Reasons

☐ Other: _____ ☐ Sharing Information with Another Provider (NOT A TRANSFER)

☐ North Arlington Pediatrics Requesting Information

List Information Needed: _____

-If transferring care, moving or sharing info with another provider, please provide us with the following: *We do not send records directly to new providers*

Practice Name: _____ Phone #: _____

City and State: _____

Do you give us permission to speak to your new doctor? ☐ Yes ☐ No Initial: _____

-Records to be released:

☐ Immunization Record & Growth Charts ☐ Entire Health Record

☐ Other (please specify): _____

-Receive Records By: *records may take up to 28 days to complete*

☐ Email (please provide one email address): _____

☐ Printed Copy (pick-up only): Phone number to call when records are ready: _____

☐ Mail: (price of shipping must be paid before records are mailed; price varies per patient.)

Mailing Address: _____

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, its partners and staff, personally and corporately, harmless from any 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 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 _____

2.I understand that if the medical records need to be mailed to me, I am responsible for the cost of mailing said records. North Arlington Pediatrics utilizes USPS Priority Mail for sending records as we get tracking numbers and will be provided to you at your request, Current USPS Priority Mail rates are used for sending the records. Initial _____

3. I understand that 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' behalf. By signing this form for someone else, you as the parent or guardian or legal representative have the legal authority to act on the patient's behalf and that you are not prohibited by Court Order from having access to request medical records. Initial _____

I authorize the following person to pick up medical records on my behalf: _____ Initial _____

Relationship to person requesting medical records: _____ Date:_____

Name of person authorizing records: _____ Signature: _____