North Arlington Pediatrics, SC
1430 N. Arlington Heights Rd, Ste. 210
Arlington Heights, IL 60004
Phone: 847-253-3600 Fax: 847-253-3912

Authorization to release or obtain Medical Records for use of 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 is as follows:
Moving _____ Please provide new address: _____
Age_____ Insurance change _____ Dissatisfaction with practice _____ Transfer of Care _____
Personal use _____ Legal reasons _____ Other _____
Sharing information with another Health Care Provider _____ (NOT A TRANSFER) Provider _____
Phone number of provider _____ Name of practice _____
North Arlington Pediatrics requesting information _____ List information needed _____

If transfer of care or moving, please provide us with the name of the practice, phone number and city and state:
Practice _____ Phone number _____
City and state _____
(We do not send medical records directly to new provider)
Do you give us permission to speak to your new doctor? Yes _____ No _____ **Initial** _____

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 protest health information. **Initial** _____

2) I am aware that the release of my medical records could take up to 14 days to complete and that North Arlington Pediatrics recommends picking up the records. **Initial** _____
Phone number to call when records are ready _____

3) I am aware that once Medical Records are ready for pick up, I will receive a call to pick them up. NAP will make two follow up calls if these medical records are not picked up on a timely basis. After the two calls, NAP can shred the records prepared and if records need to be re-copied, I could incur a charge for the 2nd request for records**. Initial** _____

4) **I understand that if the medical records need to be mailed to me, that I am responsible for the cost of mailing of 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** _____

I authorize that only the person filling out this request can pick up the medical records. **Initial** _____

I authorize the following person to pick up medical records on my behalf _____ **Initial** _____
(**Identification will be required to pick up records**)

Name of person authorizing records (printed) _____ Signature _____
Relationship to person requesting records _____ Date _____

If the patient is under 18 years of age, unless the patient is an emancipated manor, 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 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 request medical records. (Rev. May, 2022)