Medical Record Release Information

North Arlington Pediatrics
1430 N. Arlington Heights Road, Ste 210
Arlington Heights, IL 60004
P: 847-253-3600
F: 847-253-3912

- Complete the form attached. Once the form has been submitted to North Arlington Pediatrics allow 7-10 business days to be prepared. You will receive a call when the records are ready for pick up.

- Medical Records for patients transferring out of our practice will not be sent to the new physician's office. We encourage you to make a copy of your child's records before handing them over to your new office.

- If you are only in need of your child's immunization records, call the office and speak to a phone nurse. They will be able to fax over their immunization records the same day.

- If you have moved out of state and need the records mailed please add your new address to the bottom of the transfer form. You will receive a phone call letting you know when your records will be mailed. If you do not receive the records within 2 weeks of the phone call, please call our office.

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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.