Pediatric Health Associates
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Photo ID of Parent, Legal Guardian or Patient (if over 18) is required to request Medical Records.

Immunization information is available at no charge. Other requests and fees will be handled by Datafile Technologies.
Please allow two weeks to copy records. Fax completed form to 630-778-8958 ATTN: Bev.

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION FOR THE FOLLOWING PATIENT(S):

Name: ______________________________ DOB: ______________________

Name: ______________________________ DOB: ______________________

Name: ______________________________ DOB: ______________________

RELEASE RECORDS TO:

MAIL records to:

Name: ____

Address: ______________________City: ______________State: ________Zip: _______

FAX records to Name: ______________________________**FAX**: ___________________

E-MAIL records to: ____

Signature: ______________________ Relationship to Patient: __________ Date: ______

PLEASE CHECK INFORMATION TO BE RELEASED:

_______ Immunizations Only
_______Medical Records for Date Range: _________________ to _________________
______ All Medical Records

Phone number where you can be reached for any questions: ______________________________

I UNDERSTAND THAT THIS MAY INCLUDE THE FOLLOWING INFORMATION:
Check any areas that you want information released!!!

____ AIDS ____ HIV ____Drug/Alcohol Abuse ____ Mental Health issues ____ADHD/ADD

Signature: ____

Records are being requested for the following reason(s):

_______ I am remaining a patient but am seeking care from a specialist physician. _______ I am moving out of this area.
_______ I have a new insurance and must transfer care.
_______Other (please Specify):
____

THIS AUTHORIZATION IS VALID FOR 60 DAYS FROM THE DATE SIGNED ABOVE. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME.

Date of Revocation: _____________ Revoked by (Name): ______________________________

THE FACILITY, ITS EMPLOYEES, OFFICERS, AND PHYSICIANS ARE HEREBY RELEASED FROM ANY LEGAL RESPONSIBILITY OR LIABILITY FOR DISCLOSURE OF THE ABOVE INFORMATION TO THE EXTENT INDICATED AND AUTHORIZED HEREIN.

***Office Use Only Below This Line**

- Medical Release and Photo ID scanned to Allscripts to info requested Initials: ________ Date: ____________
- Medical Release sent to Bev Initials: ________ Date: ____________