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

Prepayment is required before chart is copied
Immunization information is available at no charge
Please allow two weeks to copy records
Fax completed form to 630-717-9638

PEDIATRIC HEALTH ASSOCIATES, LTD.
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Authorize Release to (Name of Physician or Practice):_____

Address where records are to be mailed:_____

Fax : _____ (only immunizations can be faxed- all other records must be mailed)

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION FOR THE FOLLOWING PATIENT(S):
Name(s):_____ DOB:_____
_____ _____
_____ _____

Parent, Legal Guardian or Patient Signature* Required at the time that records are picked up.

Signature: _____ Relationship to Patient: _____ Date: _____
***If over 18, patient signature required**.

PLEASE CHECK INFORMATION TO BE RELEASED:

- ___ Immunizations Only (no charge)
- ___ All Medical Records 735 ILCS 5/8-2001(d)
  ($1.05 per page for pages 1-25) + ($.70 per page for pages 26-50) + ($.35 per page for pages 51 and up)
  _____phone number where you can be reached for total.

I UNDERSTAND THAT THIS MAY INCLUDE THE FOLLOWING INFORMATION:
Check any areas that you do NOT want information released

- ___ AIDS ____ HIV ____Drug/Alcohol Abuse ____ Mental Health issues ____ADHD

PLEASE CHECK APPROPRIATE SPACE:

- ____ 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):_____

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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**********

- Amount Paid:_____ Date Paid:_____ Paid by: __CK __CH __CA
- Records **Mailed** to: (name)_____ Date:_____
- (address)_____ Initials:_____

- Records **Picked up** by: (signature)_____ Date:_____
  Photo ID copied: Initials:_____

- Records **Faxed** to: _____Date:_____Initials:_____
  Fax number:_____