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

Prepayment is required before chart is copied
Please allow two weeks to copy records
Fax completed form to 630-717-9638 or email to pha@pedhealth.net

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

I authorize release of records to: (Name of Physician or Practice): _____

Fax or email where records are to be sent: _____

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

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

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

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

PLEASE CHECK INFORMATION TO BE RELEASED:

- ___Last physical and immunizations Only
- ___**All** other medical records via electronic
- ___All other medical records via mail will apply the following fees 735 ILCS 5/8-2006
  ($0.55 per page for pages 1-25) + ($0.37 per page for pages 26-50) + ($0.18 per page for pages 51 & up)
  Phone number where you can be reached for total charges _____
  Address where records are to be mailed _____

Check the specific medical records that you want included in this request, otherwise these records will not be released.

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

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):_____

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 **Released** to: (signature)_____ Date: _____
  Photo ID copied: _____ Initials: _____

- Records sent **Electronic** to: _____ Date: _____
- Fax # or email: _____ Initials: _____