Caring for your future

All About Kids Pediatrics

…from cradle to college

1250 North Mill St. Suite 100
Naperville, IL 60563
(630)355-6996 Fax (630)355-0026

Authorization for Release of Medical Information

I hereby authorization you to release medical information for the named patient to:

_____

_____

_____

In accordance with recent HIPPA law changes, please complete a separate form for *each* patient's records being requested.

Patient Name:_____DOB:_____

Address: _____

Phone # to contact if we need to reach you regarding this request:_____

Records requested (please check only ONE):

_____ Immunizations and Growth Records **ONLY** (No charge)

_____ Partial Records (includes immunizations) **Please List**: _____

_____Full Chart (includes immunizations) Processing fee per page for any copies other than immunizations: $0.39

***Please note: your records will be sent to you within 30 days from receipt of this completed form. Not filling this form out in its entirety may cause a delay in receiving your records**

***REQUIRED: Purpose of obtaining this information (answer must be given in order to receive records):**

_____I am remaining a patient

_____ I am leaving the practice. Reason for leaving the practice: _____

Additional Information for our office:

_____I am moving out of this area. My new address will be:_____

_____I am seeking continuing care from the following specialist:_____

_____I am transferring to another doctor: _____

I release this office from all legal responsibilities or liability for disclosure of the above information that may arise from this authorization. I agree to pay any fees for copying each person's record requested.

Signature_____Date:_____Relationship:_____

Parent/Guardian (or if 18+ year sold, self) signature once records are received:

Signature_____Date:_____Relationship:_____