



Pediatric Partners, S.C. Authorization to Release Health Information

767 Park Avenue West, Suite 230, Highland Park, IL 60035  
870 West End Court, Suite 205, Vernon Hills, IL 60061

Phone: 847-681-7100 Fax: 847-681-7110  
Phone: 847-362-4155 Fax: 847-362-4425

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Contact Number: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize Pediatric Partners, S.C. to release healthcare information of the patient named above to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_

All healthcare information

Other: \_\_\_\_\_

Yes  No I authorize the release of STD results, HIV/AIDS testing, genetics whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes  No I authorize the release of any records regarding drug, alcohol, or mental health treatment (to include ADD or ADHD) to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Copying Fees 2012

Handling charge	\$25.55	\$25.55
Copy pages 1 through 25	\$0.96	
Copy pages 26 through 50	\$0.64	
Copy pages in excess of 50	\$0.32	
Copies made from microfiche or microfilm	\$1.60	

Total: \_\_\_\_\_

Pick Up  Mail

Plus postage

Per State of IL Comptroller ([www.ioc.state.il.us](http://www.ioc.state.il.us))

Reason for Leaving: \_\_\_\_\_

If returning to the practice after an absence records will have to be recovered from our off site storage. There is a recovery fee to be paid by the patient/parent.

Recovery fee = \$30.00 + \$20.00 trip charge per chart.

**Please allow up to 14 business days for processing your request**

Patient/

Guardian Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

For Office Use Only:

Date Needed By \_\_\_\_\_ Amount Paid: \_\_\_\_\_ Method of Payment: Cash Check Visa MC Discover

Records Reviewed By: \_\_\_\_\_ Personal Balance Paid: Yes \_\_\_\_\_ No \_\_\_\_\_