Children's Health Partners

Laurel M. George, MD
Karen M. Kreiling, MD
Michelle L. Pierce, MD
Brooke D. Scherer, MD
Janie L. Canner, DO
Radhika C. Shah, MD
Pediatrics

REQUEST FOR RELEASE OF MEDICAL RECORDS

I, _____/_____, hereby
(requestor's name) (relationship to child)
give my consent to Children's Health Partners to release to:

Please select one:

☐ Self
- Pick Up Date: _____
- Or mail to (circle one): current address / new address

☐ _____
(Name of physician, health care facility, etc)
_____
(Street Address)
_____
(City, State, and Zip Code)

☐ _____
(Fax to new physician – Growth and Immunization sheets only)

For _____ _____
(Child's Name 1) (Date of Birth)

_____ _____
(Child's Name 2) (Date of Birth)

_____ _____
(Child's Name 3) (Date of Birth)

_____ _____
(Child's Name 4) (Date of Birth)

I authorize the following specified information to be released (select one):

☐ Immunizations & Growth Charts Only
☐ All Records (Fee per Child)

The following highly CONFIDENTIAL items must be checked off to be included in the disclosure:

- ☐ HIV/AIDS related health information/records (410 ILCS 305/9)
- ☐ Behavioral or mental health information/records (740 ILCS 110/1 et seq)
- ☐ Drug/alcohol diagnosis, treatment, referral information (20 ILCS 301/30.5; 42 CFR Pt. 2)
- ☐ Genetic testing information/records (410 ILCS 513/30)

Reason for release of records:

☐ Moving: _____
(New Street Address)
_____
(New City, State, and Zip Code)
_____
(New Phone Number with Area Code)

☐ Insurance Change
☐ Other:

_____

Signature:_____ **Date:**_____

OFFICE USE ONLY:
Task Completed Date: _____ Completed by: _____
Fee Collected: $_____ Payment Method: _____ Received by: _____

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2007 95th Street
Lower Level, Suite A
Naperville, IL 60564
630-848-1700
Fax 630-848-1718
childrenshealthpartners.com