



CHILDREN & TEENS MEDICAL CENTER

CONSENT FOR RELEASE OF MEDICAL RECORDS AND RELEASE OF SPECIFIED PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____

This consent permits the use and/or disclosure of the following protected health information for the above named patient(s) :

- Entire medical record (most physicians do not want the entire medical record)
\$25.00 charge per child + .25 cents per page over 100 pages - prepayment for copy of the entire manuscript
** Limited to one copy of the entire manuscript per year
Medical record summary (most physicians prefer this) - No charge
Immunization record only - No charge
Specified portion of the medical record (please detail) _____
Fax copy of a specific portion of the medical record (please detail) _____
Fax # _____

Children & Teens Medical Center will copy and prepare the above medical information within 60 days of the date of this notice.

The above named protected health information is being released to :

Name _____ Phone Number _____
Address _____ Fax Number _____

The above named protected health information is being released for :

- Change in insurance _____ Health insurance claim _____
Transferring to another physician _____ Second opinion / specialist _____
Other : please specify _____

I hereby consent to the release of my specified protected health information to the above named recipient for the above named reason(s). When my information is used or disclosed pursuant to this consent it may be redisclosed by the recipient and may no longer be protected by the federal HIPAA privacy rule. In the event my above named protected health information is being permantely transferred to another physician , as named above, I release Children & Teens Medical Center from all legal responsibility or liability that may arise from the transfer of said material and do fully understand that said patient(s) care is being transferred to the above named physician.

Signature _____ Relationship to patient _____
(parent or legal guardian)

Date _____ Witness _____
(signature)

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