Children and Teens Medical Center

Request for Release of PHI from a Hospital or other Medical Provider

Name of Patient: ____ Date of Birth: ______________

Address: ____

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We are requesting a release of information from:

Name of Doctor/Hospital: ____

Address: ____

____

Fax#: _________________________ Phone#: ____

Date of Service: From: ______________ To: ______________

Please Release the following:

Consult notes ___________ ER Report _______________

Lab/PKU report __________ Immunization Dates ________

XRAY __________________ Weight __________________

NB/DC Papers ___________ Growth Chart _____________

Other: ____

Please release for the following purpose

Continuing medical care: _______________ Legal: ___________________

Other: **We are the patients primary care provider**

Please release information to:

Name of Doctor/Facility: Children and Teens Medical Center
Address: 1701 W. Wise Road, Schaumburg, IL 60193
Kindly fax to: 847-895-7810

Message: ____

I hereby authorize the release of my specified protected health information from the above stated facility and/or Physician to be release to Children and Teens Medical Center effective as of today's date and expiring within 6 months from the date of this request. I understand that I may revoke my authorization at any time in writing except to the extent that action has already taken. Information release outside of Children and Teens Medical Center may be redisclosed and no longer protected by HIPPA privacy laws.

Signature: ______________________________ Print Name: __________________________

Relationship to patient: ___________________ Date: _________________________________

(Expiration: 6 months from the date of request unless otherwise specified)
Date:09/20/2018 Practice folders/our forms/request for release of PHI 092018