# CHILDREN & TEENS MEDICAL CENTER

## 2014 PARENTAL CONSENT FOR RELEASE OF MEDICAL RECORDS AND RELEASE OF SPECIFIED PROTECTED HEALTH INFORMATION

**Today's Date:** _______________

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 - The charge for copying medical records is $0.99 cents per page for the first 25 pages, $0.66 cents per page for pages 26-50, $0.33 cents per page for pages over 50, plus actual postage. A $26.38 additional handling fee can be charged if the request is made by an entity other than the patient or their representative.

_______ Parental request for copying individual pages of the medical record are $0.99 cents per page for the first 25 pages, $0.66 cents per page for pages 26-50, $0.33 cents per page for pages over 50, plus actual postage.

_______ Immunization record, growth chart, & problem list - **No charge**

The above named protected health information is being released to:
Name ______________________________ Phone Number ______________________
Address ______________________________ Fax Number: ______________________
Address ______________________________

The above named protected health information is being requested due to:
_____ Transfer/New Physician
Name: ______________________________ Phone Number: ______________________
Address: ______________________________ Fax Number: ______________________
Address: ______________________________
_____ Second Opinion/Specialist:
Name: ______________________________ Phone Number: ______________________
Address: ______________________________ Fax Number: ______________________
Address: ______________________________
_____ Moving:
New Address: ______________________________ Phone Number ______________________
Address: ______________________________
_____Other (state reasons): ______________________________________________
______________________________________________

***Children & Teens Medical Center will copy and prepare the above medical information within 30 days of the date of this notice. Payment for medical records copying is due PRIOR to and/or at the time of records release.***

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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 re-disclosed 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 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 ______________________
(Name)

**1701 W. Wise Road**
**Schaumburg, Il 60193**
**Phone: 847-895-2900**
**Fax: 847-895-7810**

**27401 W. Highway 22, Suite 103**
**Lake Barrington, Il 60010**
**Phone: 847-382-8900**
**Fax: 847-382-0150**

**620 S. Main Street**
**Algonquin, Il 60102**
**Phone: 847-854-5900**
**Fax: 847-854-5971**

**9401 Ackman Rd**
**Lake in the Hills, IL 60156**
**Phone: 224-569-4100**
**Fax: 224-569-4101**