Transfer Out Form

Northwest Suburban Pediatrivs, S.C.
3335 N. Arlington Hts. Rd. Ste C
Arlington Heights, IL 60004
Phone: 847-788-8300 Fax: 847-788-8306

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

Patient: _____ DOB:_____

Address: _____

_____

Phone: _____

Reason for request: _____

Please have my physician send the following information: (mark all that apply)

Complete Records	□	X-Rays	□	Consults/Specialist Records	□
Progress Notes	□	Health & PE	□	Prior Physicians Records	□
Labs	□	Shot Record	□		

****** Complete records are those of NW Suburban Peds physicians only. If you wish to include records from referring and/or previous physicians please be sure to check the consults/specialist records and/or prior physician's records boxes. NW Suburban Peds only guarantees the accuracy and completeness of records generated by a NW Suburban Peds physician. ******

I,_____, certify the above request is accurate and hereby authorize the release of these records.

FROM: _____
Address: _____
_____
Phone: _____
Fax: _____

TO: _____
Address:_____
_____
Phone: _____
Fax:_____

*** I agree to pay all fees associated with this release, based on the standard fees outlined below. I understand that all section of this form must be completed before it can be processed. ***

_____ _____ _____
Signature of Parent / Guardian Date Phone

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I understand that I am giving my permission to release information in my medical record that may include information relating to psychiatric treatment, drug/alcohol treatment, AIDS/HIV testing or treatment of sexually transmitted disease, unless otherwise indicated. I understand that the heath care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to which disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be re-disclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

**** I understand that a reasonable fee may be charged with these records. If you are under the age of 18 years old there is $25.00 charge for medical records. Additional $10.00 charge for certified mail****