

Authorization to Release Medical or Protected Health Information

Patient Name

Patient Date of Birth

Information to be released by Vernon Hills Pediatric Associates, Ltd.

- Completion of School Form (\$10)
- Completion of Camp Form (\$10)
- Full Records (see charges below)
- Immunization & Growth Record (\$10)

<u>Charge per Page</u>	<u>Number of Copies</u>
.89 per page	first 25 pages
.59 per page	26-50
.30 per page	+50

(Rates indicated per the State of Illinois)

Records are to be mailed to the following home address (we do not forward records directly to another medical facility):

Name _____
 Address _____
 City _____ ST _____ Zip _____
 Phone Number _____

OR

Records are to be picked up at:

- Gurnee Location
- Vernon Hills Location

Reason for Request:

- Moving
- Insurance Change
- Patient Age
- Other (please explain) _____

Signature of patient, parent or guardian

Relationship to patient(s)

Date

Print Name

This form must be completed by parent or guardian for minor children. For patients 18 years and older, only the patient may complete and sign for release of records.