Associated Pediatric Partners, S.C.

Request for Transfer of Medical Records

Associated Pediatric Partners prides itself in being both professional and efficient with requests from patients regarding routine transfer of medical records. According to HIPAA practice policy (reference: https://www.hhs.gov/hipaa/for-professional/privacy/guidance/access/index.html), medical records must be requested by the patients themselves, or their legal guardians, via written medical release forms.

The consent form to release medical records should be sent directly to our office by the patients. All requests for medical record transfer requests will be completed no later than 30 days after the receipt of the request of medical records transfer request from the patient.

In addition, medical record transfer fees are required to be paid in full by the patient prior to transferring records. **The fees for medical record transfer are calculated according to the standards set by the State of Illinois Medical Society –** see last page for fee schedule. Patients are expected to request and receive all aspects of the medical records in its entirety in order to benefit the care of the patient, especially to ensure optimal ongoing pediatric care. We will not be sending out partial medical records of the patient's chart prior to fulfilling the transfer request. All patients should be aware of the appropriate time period required to process the medical chart and plan their ongoing medical care accordingly.

Please choose from options below. Kindly complete, sign and date, and return this form to us together with the completed Authorization for Release of Patient Health Information. **Both signed forms are required to process your request.**

Sign: _____ Date: _____

Patient Name: _____

_____I choose to obtain my child's full medical records per the fee schedule.

_____I choose not to obtain my child's full medical record. The medical record will be placed in secure storage. I understand there may be an additional $100.00 fee to retrieve medical records at a later date.

Respectfully,

The Doctors of Associated Pediatric Partners S.C.

Associated Pediatric Partners, S.C.

Authorization for Release of Patient Health Information

Patient's Name: _____ Date of Birth: _____ Date: _____

Address: _____ Phone: _____

Email: _____

Please list who will receive this record:

Office/Facility: _____ Phone Number: _____

Address: _____

Method of Delivery (choose one if EHR sharing not available):

___ US Mail ___ Fax (provide number) _____ Pickup at: ___ Northbrook Office ___ Buffalo Grove Office

Email to: _____ Who will pick up: _____

Reason for Request: ___ Moving out of area ___ Dissatisfied

___ Seeing a specialist/internist ___ Other (please explain): _____

Choose information to be disclosed by Associated Pediatric Pediatrics SC:

Type of Records Requested: (A Records Fee May Apply) **(Please check ONE)**

___ Camp Form ___ School/Sports Form ___ Immunization Record

___ Growth Chart ___ Allergy History ___ Lab Results

___ Entire Health Record ___ Other (please explain): _____

Dates of Service Requested (last 4 years of visit notes is default), or from: _____ to _____

Signature of patient or legal representative: _____

Relationship to patient: _____ Date: _____

Patient Signature _____ Date: _____
(12 yrs. or older if sensitive information is requested)

Sensitive Information: I understand that the information in my record may include information related to sexually transmitted diseases, AIDS/HIV, birth control, and drugs/alcohol diagnosis, treatment and/or referral information. It may also include information about behavioral or mental health services.
Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information may then not be protected by federal confidentiality rules. I understand and accept full responsibility for the medical records I am requesting, and relinquish Associated Pediatric Partners S.C. of all accountabilities concerning these records.
Expiration: If I do not specify an expiration date, event, or condition, this authorization will expire twelve (12) months from the date signed. Unless otherwise revoked, this authorization will expire on the following date: _____.
Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing, and I understand the revocation will not apply to information already released based on this authorization.

For office use:
Reviewed by: Initials:_____ Date: _____ Record Fees Due:_____ Amount Paid: _____ Rcvd By:_____

Associated Pediatric Partners, S.C.

FOR OFFICE USE – DO NOT COMPLETE

PATIENT COPYING CHARGE NOTIFICATION SHEET

Patient name: _____

Patient DOB _____ Patient ID _____

Total number of pages copied: _____

Patient request Electronic _____ Paper _____

Calculating the amount allowed under Illinois law:	
Per page charges as of January 1, 2019	
Pages 1-25 ____ @ $1.05 per page	$
Pages 26-50 ____@ $.70 per page	$
Pages 51 and over ___@ $.35 per page	$
Sub-total for paper record copying only	$
* (For electronic records provided in electronic format, charge is reduced by 50%)	$
Handling fee	$25.00
ADD mailing charge	$
Total due	$