

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.

**Patient acknowledges that once receive these records they become responsible as the custodian of the records and will provide them to future medical providers as necessary. Requests for full medical records are emailed via secure email to the patient directly.**

**This request page, and the Authorization for Release of Patient Health Information** below, should be sent directly to our office by the patients. All requests for medical record transfer requests are processed as quickly as possible, and will be completed no later than 30 days after the receipt of the medical records transfer request from the patient. However, if a fee applies, then record requests will be completed no later than 14 days after payment is processed by our billing department.

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. 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: \_\_\_\_\_

Select one option:

\_\_\_\_\_ I choose to obtain only my child’s immunization history and growth chart at no charge. The medical record will be placed in secure storage. I understand that I may retrieve the full medical records at a later date if necessary, per the fee schedule. **These records can be faxed to new doctor.** Kindly provide the fax number.

\_\_\_\_\_ I choose to obtain my child’s full medical records per the fee schedule. Sent via secure email to patient, and new provider if their email is given on the application form.

Respectfully,

The Doctors of Associated Pediatric Partners S.C.

Email to: [frontdesk@associatedpediatricpartners.com](mailto:frontdesk@associatedpediatricpartners.com) Fax to: 847-243-8679

Associated Pediatric Partners, S.C.

## Authorization for Release of Patient Health Information

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Email for records: \_\_\_\_\_

### Please list who will receive this record:

Office/Facility: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

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

Fax (provide number, and max 20 pages) \_\_\_\_\_

Email to provider: \_\_\_\_\_

**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 (no fee)

Growth Chart (no fee)                       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: \_\_\_\_\_