Sanders Court Pediatrics, Ltd.
1450 Busch Parkway Suite 130
Buffalo Grove, IL 60089
Phone: (847)499-3070
Fax: (847)499-3089

Sanders Arlington Pediatrics
1051 W. Rand Road Suite 103
Arlington Heights, IL 60004
Phone: (847)259-5900
Fax: (847)259-4508

Authorization for Release of Patient Health Information (Request for Records)

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

Address: _____ **Phone:** _____
(Street, city, state, zip code)

Please list where Sanders Court Pediatrics is *requesting medical records FROM*:

Facility/Office: _____ **Fax Number:** _____

Address: _____ **Phone Number:** _____

City, State: _____

Dates of Service Requested: _____ **Reason for Request:** _____

The following information is to be disclosed to Sanders Court Pediatrics: (Please check one box for each item)

Type of Records Requested:

☐ Problem List ☐ Immunization Record ☐ Medication List ☐ Well Visit(s)

☐ Growth Chart ☐ Allergy History ☐ Lab results ☐ Other: _____

OR ☐ Complete Record

Please send the requested information to: (Circle One)

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_____ _____
Signature of patient or legal representative Date

_____
Relationship to patient

Sensitive Information: I understand that the information in my record may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol or drug abuse.
Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure 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.
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.
Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____. If I do not specify an expiration date, event or condition, this authorization will expire in 12 months from date signed.