Palatine Pediatrics

Christine Duong, M.D.
236 E. Northwest Highway, Suite A
Palatine, IL 60067
Phone: 847-359-5000 • Fax: 847-359-5395

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Payment of all applicable fees is required in full prior to records being copied
Please allow 2 weeks for copying of records.

Child's Name: ______________________________ **Date of Birth:** ______________

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PLEASE RELEASE RECORDS FROM: Palatine Pediatrics / Christine Duong, M.D.
236 E. Northwest Highway, Suite A
Palatine, IL 60067

PLEASE RELEASE RECORDS TO:

Name: ______________________________

Street Address: ______________________________

City: ______________________________ State: __________ Zip Code: ______________

Phone: ______________________________ Fax: ______________________________

RECORDS TO BE RELEASED:

☐ Vaccine Record, Growth Chart & Last Well Visit Note **(no charge for 1st copy)**

☐ ALL Records **(Standard record copying fees per 735 ILCS 5/8 2001 (d) as outlined below)**

☐ Other Records **(Standard record copying fees per 735 ILCS 5/8 2001 (d) as outlined below)**

(please specify "Other" records): ______________________________
Standard record copying fees per 735 ILCS 5/8 2001 (d): ($29.48 Handling fee) + ($1.11 per page for pages 1-25) + ($0.74 per page for pages 26-50) + ($0.37 per page for pages 51 and up).

REASON FOR RELEASE OF INFORMATION:

☐ Transfer to New Physician ☐ Legal Counsel ☐ Other (please specify): ______________________________

RELEASE RECORDS BY: ☐ Certified Mail ☐ Pick-Up ☐ Fax (**Maximum 10 pages**)

Printed Name of Legal Guardian or Patient (age 18 +) ______________________________ **Date:** ______________

Signature of Legal Guardian or Patient (age 18+): ______________________________ **Phone:** ______________

RELEASE OF HIGHLY CONFIDENTIAL RECORDS:
I specifically consent to the release of highly confidential records including mental health, developmental disability, drug or alcohol abuse, sexually transmitted diseases (STDs), sexual assault, child abuse or neglect, genetic testing, and HIV/AIDs testing and treatment.

Printed Name of Legal Guardian or Patient (age 18 +) ______________________________ **Date:** ______________

Signature of Parent/Legal Guardian/Patient (age 18+): ______________________________