WHOLE CHILD Pediatrics

WHOLE FAMILY Integrative Health

Medical Records Request Form

By signing the Medical Records Request Form, I approve for the following Protected Health Information to be released to Whole Child Pediatrics/Whole Family Integrative Health for myself or my child from:

Provider_____

Address/City/State/Zip_____

Phone_____ **Fax**_____

Patient Name:_____ **Date of Birth:**_____

[ ] Complete Records	[ ] History & Physicals	[ ] Progress Notes
[ ] Plan of Care	[ ] Lab Reports	[ ] Radiology Reports
[ ] Pathology Reports	[ ] Treatment Record	[ ] Operative Reports
[ ] Hospital Reports	[ ] Medication Records	[ ] Other (please specify)
[ ] Vaccine Records		

I understand that I must check one or more of the following types of health information that I do not want released to the above-named recipient. I understand that if I do not check any of the three following items, the information released to the named recipient may include the following:

[ ] Diagnosis, evaluation and/or treatment for alcohol and/or drug abuse

[ ] Records of HTL V-III or HIV testing (Aids test) result, diagnosis and/or treatment

[ ] Psychiatric, psychological records or evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, test, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans and/or evaluation.

Release records to Whole Child Pediatrics/Whole Family Integrative Health by faxing to (630) 385-2934 or mailing to address below on a C.D.

Purpose for the request:_____

_____ _____

Patient or Guardian Signature Date

Witnessed by:_____ Date:_____

I understand I have the right to revoke/withdrawal this authorization at any time as long as it is in writing to the medical record contact person at this site except to the extent the action has already been taken to request this information. Authorization is valid unless revoked but will expire in one year after signing. I understand the information released in response to this authorization may be re-disclosed to other parties.