Informed Consent - For Disclosure of Patient Health Care Information
For Patients Over 18 Years Old

PATIENT INFORMATION

Patient Name: ____
PRINT

____
SIGNATURE

Cell Phone # ______________________ Birthdate: ____/____/_____

I GIVE MY PERMISSION TO:

Medical Pediatrics, Ltd.
1700 W. Central Road, Suite 200
Arlington Heights, IL 60005
Phone: 847-392-1880
Fax: 847-392-1980

To discuss information from the Doctor regarding my:

(CHECK EACH CATEGORY TO BE DISCUSSED)

- o Medical Condition
- o Treatment Plan
- o Lab Results
- o Medication

With the Person/People designated below:

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