RELEASE OF MEDICAL INFORMATION

All information contained in the medical record is confidential. A properly completed and signed authorization is required for the release of the following information.

PATIENT INFORMATION

Patient name: _____

Address: _____ Birth Date: ___/___/___

City: _____ State: _____ ZIP: _____

Primary phone: _____ Alternate phone: _____

RELEASE FROM:	**RELEASE TO:**
Doctor's Office: Medical Pediatrics	**Doctor's Office or Name of Patient/Guardian:**
Address: 1700 W. Central Road Suite 200	_____
City: Arlington Heights **State**: IL **ZIP**: 60005	**Address**: _____
Phone: (847) 392-1880 **Fax:** (847) 392-1980	**City**: _____ **State**: _____ **ZIP**: _____

INFORMATION TO BE RELEASED

___ Full details of medical record

___ Office visit notes only

___ Immunization records only

___ Lab results only (specify) _____

___ X-ray reports only (specify) _____

___ Hospital records only (specify) _____

PURPOSE/NEED FOR INFORMATION:	**METHOD OF RELEASE:**
__ Taking records to another doctor __ Moving __ Legal purposes __ Insurance Purposes __ Other: _____	__ U.S. Mail __ Fax __ Telephone __ To Patient - Paper copies __ To Patient - CD (scanned records) __ U.S. Mail - CD (scanned records)

_____ _____

SIGNATURE DATE

OFFICE USE ONLY

Information indicated above released on: _____

Signature of individual releasing information: _____

01/2013