Pediatric Care P.C.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND/OR INFORMATION

☐ **TO** ☐ **FROM** ☐ **TO** ☐ **FROM**

Pediatric Care P.C.
27790 W. Highway 22, Suite 7
Barrington, Illinois 60010
847 382-7337
847 382-7377 FAX
email@pediatric-care.org

_____
_____
_____
_____

I request and authorize the release of medical records or information for the following:

Patient's Name: _____ **DOB:** _____

Patient's Name _____ **DOB:** _____

Patient's Name: _____ **DOB:** _____

Patient's Name _____ **DOB:** _____

REASON FOR REQUEST:

☐ **Moving** ☐ **New Insurance Plan**

☐ **Specialist Referral** ☐ **New Physician** _____
Name of New Physician

☐ **Other** _____

I attest that I am authorized to make this request

Signature: _____ **Relationship:** _____ **Date:** _____

Please Select Records Requested : (fees apply if requesting from Pediatric Care PC)

☐ Immunization records only $5.00
☐ School Form * $5.00 *Additional Copy
☐ Summary Sheet & Immunizations $10.00
☐ Complete medical records (Varies by size of Chart)
Available on Disc

Payment:

CC# _____ Exp Date: _____/_____ 3 Digit #on Back _____
Check :_____

Please: ☐ Mail ☐ Hold for pick up
☐ Fax or email (Immunization records or school forms only under 10 pages)

Fax Number or email _____

***** FOR OFFICE USE *****

Date request received _____ **Date Sent:** _____

Sent by _____ **FEES DUE** _____

Payment received _____ **Cash/CC/ Check#** _____