

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 \$25.00

Payment:

CC# _____ Exp Date: ____/____/____ 3 Digit #on Back _____
Check : _____ or pay online @ pediatric-care.org click on payment tab

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# _____