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 $10.00
☐ School Form * $10.00 *Additional Copy Summary
☐ Sheet & Immunizations $15.00
☐ Complete medical records $30.00

Payment:

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

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

Fax Number or email _____

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

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

Sent by _____ **FEES DUE** _____

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