AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

TO: _____

_____

_____

I HEREBY AUTHORIZE YOU TO RELEASE MEDICAL INFORMATION FOR THE NAMED PATIENT (S) TO:

A.B.C. PEDIATRICS, LTD.

1331 W. 75th Street, Suite 300 ***Phone 630 355-0003***
Naperville, IL 60540 ***Fax 630 355-9822***

Gus A. Rousonelos, M.D. ***Erin L. Shanks, M.D.***
Karolyn D. Law, M.D. ***Ushma Patel, M.D.***
Pamela M. Persak, M.D.

CHILD/CHILDREN NAME (S)

_____ **DOB:** _____
_____ **DOB:** _____
_____ **DOB:** _____
_____ **DOB:** _____

Disclosure will include (check all that apply):

All Records/All Dates (Includes, but not limited to HIV, Mental Health and Substance Abuse Information)

Lab Reports Immunizations Other _____

Progress/Physician Notes Radiology Report Emergency Report Nurses Notes EKG/EMG/ EEG Report Consultation

Records for the period (dates) from
_____to_____

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent the action has already been taken to release this information.

I release this office from all legal responsibilities or liability for disclosure of the above information that may arise from this authorization.

Parent Signature: _____ Date: _____
Or Legal Representative: _____ Relationship: _____