

TO: A.B.C. PEDIATRICS, LTD.
1247 Rickert Drive, Suite 101
Naperville, IL 60540

Fax (630) 355-9822

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

CHILD/CHILDREN NAME (S):

_____ **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 only (No Charge) Other _____
 Progress/Physician Notes Radiology Report Emergency Report Nurses Notes EKG/EMG/EEG Report Consultation

Records for the period (dates) from _____ to _____

Purpose of the information is:

- ___ **I am remaining a patient, but am seeking care from a specialist Physician.**
___ **I am moving out of this area. My new address is: _____.**
___ **I have a new insurance and must transfer care. My new insurance is _____.**
___ **Other (list reason): _____.**

I release this office from all legal responsibilities or liability for disclosure of the above information that may arise from this authorization. I agree to pay \$25.00 copying fee for each child's records requested.

Guardian Signature: _____ Date: _____ Relationship: _____

For office use only:

	Date	Initials			
Signed authorization	_____	_____			
Fee Paid:	_____	_____	Check	Charge	Cash
Doctor pull records	_____	_____			
Records copied	_____	_____			
EMR records printed	_____	_____			
EMR immunizations printed	_____	_____			
EMR scanned items printed	_____	_____			
Records Mailed:	_____	_____			
Records Picked up:	_____	_____			