

**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.***

*1247 Rickert Drive, Suite 101  
Naperville, IL 60540*

*Phone 630 355-0003  
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 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:** \_\_\_\_\_

