PediaGroup Associates

6300 W. Roosevelt Road, OakPark, IL 60304
Phone: (708) 848-8240 * Fax: (708) 383-2135

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS

Date: _____

1. Patient Name:_____ Date of Birth: _____

2. Patient Name:_____ Date of Birth: _____

3. Patient name:_____ Date of Birth: _____

I HEREBY AUTHORIZE: Cynthia Gould, M.D., Karen Walker, M.D., Alka Srivastava, M.D., Ann Fischer, M.D.

TO: ___ OBTAIN ____RELEASE _____
Name of Doctor/facility

_____
Address

_____
City, State, Zip

_____
Phone Fax

Medical records being requested:
ALL medical records _____ vaccine record _____ radiology reports_____ Other _____

Reason for request:
Relocated _____ Insurance _____

Other:_____
(positive or negative, we appreciate your comments)

*Medical record fee of $35.00 *Please allow 7-14 business days for processing

I authorize medical information to be released as indicated above. I understand this release is effective for 1 Year from the date of execution. However, I may revoke my consent at any time by providing written revocation to the above named physician.

_____ _____
Parent signature Date

_____ _____
Witness Date