North Suburban Pediatrics, S.C.

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Authorization for Disclosure of Confidential Information

Patient Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

Purpose Needed: _____

I authorize North Suburban Pediatrics to release the following information from the above named patients records

_____ All Records

_____ Consultations	_____History of Physical	_____Alcohol/Chemical
_____ Discharge Summary	_____ Labs	_____Education History
_____ER Report	_____Radiology	_____Operative Reports
_____ HIV Anitbody Report	_____Psychiatric	_____Genetics

Other: _____

Release to Following

Name or Location: _____ Relation: _____

Address: _____

_____

Signature of Patient or Authorized Legal Guardian | Relationship | Date

I understand that this consent is only valid for 90 days from the date of signature

and that there is a charge for copying medical records

northsuburban

PEDIATRICS