

Pediatric Associates, P.C.
Medical Release Form

Patient Information (PLEASE PRINT):

Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone #: _____

Release patient records from:

Clinic Name: _____ City: _____

Phone #: _____ Fax#: _____

Forward records to:

Pediatric Associates P.C.
3749 W. 95th St. Evergreen Park IL 60805
14552 John Humphrey Dr. Orland Park IL 60462
Ph: (844) 372-7672 Fx: (708) 499-1511

This medical release form is only valid 30 days from the signature date.

I, _____, authorize the above stated clinic to release the
(Print name of parent/guardian)
patient's medical records to Pediatric Associates P.C.

Signature of Parent/Guardian

Printed Name

Date Signed