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:

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

Forward records to:

Clinic Name:_____ **City:**_____

Phone #:_____ **Fax#**:_____

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 the requested receiver.

_____ _____ _____
Signature of Parent/Guardian Printed Name Date Signed