

**Authorization to Release Medical Records**

**For Record Release or Copies:** By signing this authorization, I authorize the party listed below to use and/ or disclose certain protected health information (PHI) about me/ my child.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Date of Birth

**Information Release By Mundelein Pediatrics, S.C.**

**\_\_** Immunizations and Growth Records Only (no charge) \_\_ Full Records

**Information to be Excluded/ Not Released**

\_\_ Mental Health \_\_ Drug/ Alcohol Treatment \_\_ Other \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

**Please Release Medical Records to:**

Name/ Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Obtain From:**

Name/ Address

\_\_\_\_\_\_\_\_Mundelein Pediatrics 1170 E. Belvidere Road Suite #106 Grayslake IL 60030\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please indicate the reason for request:**

\_\_ Moving \_\_ Change in insurance plan \_\_ Over 21 \_\_Personal \_\_Other (please explain)

**I understand and agree that I am financially responsible for the following fees associated with my request: $15 plus shipping and handling.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient, Parent or Legal Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient, Parent or Legal Guardian Phone Number

\*This form must be completed by parent or guardian in order to release medical records or a minor. Payment must be made before obtaining medical records.

**Mundelein Pediatrics, S.C.**

**Pediatrics-Adolescents**

**1170 E. Belvidere Road**

 **Suite #106**

**Grayslake, IL 60030**

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