Lake Shore Pediatrics, Ltd.
Authorization for Release of Information

Lake Forest Office
900 N. Westmoreland, Suite 106
Lake Forest, IL 60045
Ph: (847) 615-0700
Fax: (847) 615-0730

Barrington Office
27790 West Hwy 22, Suite 36
Barrington, IL 60010
Ph: (847) 381-2428
Fax: (847) 381-4602

Libertyville Office
1800 Hollister Drive, Suite 220
Libertyville, IL 60048
Ph: (847) 362-5707
Fax: (847) 362-4615

Patient's Name: ____

Address: ____

Date of Birth: ____

The undersigned hereby authorizes and requests **LAKE SHORE PEDIATRICS, LTD.** to:

☐ Release to ____________________________________

☐ Obtain from ____________________________________

____

☐ All medical records, or

☐ Only the following information : ____________________________________

____

I understand that my child(ren)'s medical records (including any psychiatric, alcohol or drug abuse information) may be protected by federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc.) and that in any event this consent expires automatically as described below. I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and / or alcohol abuse, mental illness or psychiatric treatment. I give authorization for these records to be released.

A $15.00 copying fee per record will be due and payable *per patient*. There is no fee for transferring immunization records only.

Specifications of the date, event or condition upon which this consent expires:

____

If left blank, this consent expires in 90 days.

Signed this _________ day of ________________________, 20 _____.

____
Signature of patient if over 18 years of age

____
Signature of parent or guardian

____
Relationship to patient

Is this patient leaving our practice? ☐ No ☐ Yes – Why? ☐ Moving ☐ Insurance ☐ Unhappy

Other ____

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