Authorization to Transfer Medical Records

I, _____, authorize Pediatric Solutions, SC to release the
(parent/guardian name)

Medical records for my child(ren):

Name:_____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Parent/guardian signature: _____ Date: _____

Information to be released (check one):

____ Immunizations only

____ Complete medical records

____ only records specified here:_____

Please send these records TO:

Doctor/Practice Name: _____

Address: _____

City, State, Zip: _____

Phone #: _____ Fax#: _____

Please (check one) _____**mail** OR _____**fax** these records

Office use:

Date records sent: _____ or faxed: _____

Date fee received: _____ By cash ___ By Check ___ (check #____) by Credit Card ____

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Arlington Heights, IL 60004
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