Today's Date: _____

680 N. LAKE SHORE DRIVE, SUITE 1050 CHICAGO, IL 60611

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ hereby authorize The Northwestern Children's Practice to copy the full medical record of the patient(s) listed below:

Patient's Name: _____D.O.B._____

Patient's Name: _____D.O.B._____

Patient's Name: _____D.O.B._____

Reason for request:

☐ Insurance ☐ New Doctor ☐ Specialist ☐Moving ☐Personal Copy

Please choose how you would like to receive your child's records:

☐ I will pick up the records. Call me when they are ready at the following number:

Home & Cell Number: _____

☐ Please mail the records to the following address:

_____

Signature of parent if child is under 18 years of age:

Parent/Guardian name (please print):_____

Parent/Guardian Signature: _____