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: ☐Immunization record ☐Insurance ☐ New Doctor ☐Moving
☐Personal Copy ☐Internist ☐ Specialist

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

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

☐ Please mail my records: (Must include name of practice if transferring out)

_____

Patient/Parent/Guardian name (please print): _____

Patient/Parent/Guardian Signature: _____
(Parent/Guardian signature required if child is under 18 years of age)

Medical Record Copies

Patients requesting copies of medical records will be charged:

$15-if picking up medical records
$20-to mail the records
No charge for Immunization record only

**A special handling fee of $10 will be charged if records must be delivered within 48 hours of the request. **

If you have access to MyChart via Lurie then you have full access to your children's medical record.