

55 E. Loop Rd. Suite 301
Wheaton, IL 60189
Phone: 630-690-7300
Fax: 630-690-7335
www.wheatonpediatrics.com



Wheaton Pediatrics, Ltd

CONSENT FOR RELEASE OF MEDICAL INFORMATION
FOR PATIENTS 18 YEARS OF AGE AND OLDER

PATIENT NAME _____

DATE OF BIRTH _____

I hereby consent to the release of medical information to:

Mother and/or Father (please list their names) _____

Other: _____

The medical information to include and be limited to:

_____ All Records
Initials

_____ Medication Records
Initials

_____ Progress/Doctors Notes
Initials

_____ Immunization Records
Initials

_____ Laboratory Data
Initials

_____ Other: _____
Initials

<OR>

_____ Do not release any medical information to anyone other than myself.
Initials

SIGNATURE: _____

WITNESS: _____

DATE: _____

DATE: _____

This consent expires one year from the date of signature.