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Wheaton Pediatrics, Ltd

TODAY'S DATE: _____

PATIENT(S) NAME AND BIRTHDATE(S): _____

I HEREBY AUTHORIZE **WHEATON PEDIATRICS, LTD.** TO RELEASE MY CHILD/CHILDRENS MEDICAL RECORDS TO:

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE NUMBER (IF KNOWN): _____

REASON FOR RECORD RELEASE:

- SEEING SPECIALIST: _____
- MOVING OUT OF STATE/AREA (NEW ADDRESS/PHONE NUMBER):

- TRANSFERRING TO ANOTHER DOCTOR/PRACTICE (IF DUE TO INSURANCE, PLEASE NOTE INSURANCE NAME): ***PLEASE NOTE:** BY CHOOSING THIS OPTION AND SIGNING THIS FORM, I AM AWARE *AND* AGREE TO TRANSFER MY CHILDS MEDICAL CARE TO THE DOCTOR/PRACTICE I HAVE CHOSEN OR IS LISTED ABOVE, EFFECTIVE ON THE DATE RECORDS ARE PICKED UP OR MAILED.

THERE WILL BE A COPYING FEE (MINIMUM \$25.00), BASED ON THE AMOUNT OF RECORDS TO BE COPIED. THIS FEE WILL BE DETERMINED BY THE MEDICAL RECORDS DEPARTMENT. PLEASE INCLUDE YOUR TELEPHONE NUMBER ON THIS RELEASE SO THEY CAN NOTIFY YOU OF THE FEE AND INFORM YOU WHEN THE RECORDS ARE READY. IT NORMALLY TAKES 2 WEEKS TO GET THE COPIES READY.

SIGNATURE OF PARENT/GUARDIAN

PHONE NUMBER

COPY FEE RECEIVED: _____ DATE PICKED UP/MAILED: _____