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:

☐ Please email the records to me at: _____

☐ 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
(No charge for Immunization record only)

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