Lake Forest Pediatric Associates
917 Sherwood Dr | Lake Bluff, IL 60044

Phone: (847) 295-1220
Fax: (847) 295-1255

Please submit this form to your previous pediatrician's office
so that they can forward your records to Lake Forest Pediatric Associates.

Authorization to Release Medical Information or Protected Health Information

Patient Name: DOB:

Entity Authorized to Release Information:

I authorize the above named entity to disclose my medical information and/or protected health information (PHI) as specified below. I understand that signing this authorization is voluntary. I understand that I have the right to revoke this authorization at any time by providing a signed, written notice of such revocation to the entity named above. I understand that I cannot revoke this authorization to the extent this authorization has already been relied upon.

Information to be released:
☐Complete Medical Record ☐Immunization Record
☐Other:_____

Please release information to:

Lake Forest Pediatric Associates
917 Sherwood Drive
Lake Bluff, IL 60044
Fax: (847) 295-1255

I have read and understand this authorization.

Signature of Patient Date

Signature of Authorized Representative Date

Name of Authorized Representative Relationship