



**AUTHORIZATION TO RELEASE MEDICAL INFORMATION
OR PROTECTED HEALTH INFORMATION**

Patient Name:

Date of Birth:

Information to be released by Lake Forest Pediatric Associates

Full Records (see charges below) Immunization and Growth Record Only (no charge)

Number of pages	Charge per page
Pages 1 – 25	\$1.00 per page
Pages 26 – 50	\$0.67 per page
Pages 51+	\$0.33 per page

Plus Postage and Handling

Please release medical records to:

Name	
Street Address	
City, State, Zip	
Phone	

Please indicate the reason for request:

Moving Change in Insurance Plan Patient age
Other (please explain)

Signature of patient, parent or guardian

Relationship to patient(s)

Print Name

Date

***This form must be completed by parent or guardian in order to release
medical records of minor children.***

For office use only

Cash Check Check number

Credit Card V MC Disc AmEX Exp Date

Mail Receipt Y N Zip Code

Updated: 2016-07-11