55 E. Loop Road
Wheaton, IL 60189
Phone: 630-690-7300
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www.wheatonpediatrics.com

Wheaton Pediatrics
A helpful hand in your child's future.

Medical Release of Records FROM Wheaton Pediatrics, Ltd.

Patient Name and Date of Birth: _____
(One request is required per child)

I Hereby Authorize Wheaton Pediatrics to release the information below to:

Facility Name, Address and Phone Number:

_____
_____
_____
(____) _____ - _____ ext. ____

*Have you registered your child or made an appointment with the new healthcare provider? ☐ Y ☐ N

Individual Name , Address and Phone Number:

_____
_____
_____
_____

*Effective date of New Address:
____/____/_____

Description of Records to be Released:

- ☐ All Medical Records
- ☐ Immunization Records/Growth Chart/Medical Summary
- ☐ Genetic Testing Information
- ☐ Information About Child Abuse/Neglect
- ☐ Information Regarding Sexual Assault/Abuse
- ☐ *Behavioral or Mental Health Information
- ☐ *Drug/Alcohol Useage/Treatment
- ☐ *HIV/AIDS Related Health Information
- ☐ *Pregnancy
- ☐ *Information Regarding Sexually Transmitted Disease
- ☐ Other: _____

* Requires consent/signature of patient 12 years and older

Reason for Record Release:

- ☐ Seeing Specialist
- ☐ Moving out of State/Area (New Address/Phone Number if not noted above)

_____
_____

- ☐ Transferring to another Doctor/Practice – (If due to insurance please make note below). **Please note that 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.

Patients who are 18+ years old and have requested records are encouraged to find an age appropriate provider. We will allow visits to our office for sick patients/adults who are signing this release for 30 days from date of signature.

_____ _____
Signature of Parent/Guardian Date

_____ _____
*Signature of Patient 12 years and up Date

_____
Phone Number

Copy Fee Received: _____ Date Picked Up/Mailed: _____