Wheaton Pediatrics
A helpful hand in your child's future.
55 E. Loop Rd. Suite 301
Wheaton, Il 60189
Phone: 630-690-7300
Fax: 630-690-7335

Medical Release of Records TO Wheaton Pediatrics, Ltd.

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

I Hereby Authorize:
Previous Doctor or Facility: _____

Hospital: ☐ CDH ☐ Edwards ☐ Delnor ☐ Good Samaritan ☐ Other _____

Misc: ☐ Specialist ☐ Other: _____

Their phone or fax number: _____

To Release My Child's Medical Records
(Description of Records to be Released)

☐ All Medical Records (excludes mental health treatment, drug abuse treatment, and HIV records)

☐ Hospital Discharge Summary only - Discharge date: _____

☐ Labs – Date of Service _____ OR ☐ Most recent (*Required for release*)

☐ Hospital Birth Records ☐ Behavioral or Mental Health Information (*The patient 12 + must authorize release*)

☐ Immunization Records ☐ Drug/Alcohol Usage/Treatment (*The patient 12+ must authorize release*)

☐ Information About Child Abuse/Neglect ☐ HIV/AIDS Related Health Information (*The patient 12+ must authorize release*)

☐ Information Regarding Sexual Abuse/Assault ☐ Information Regarding Sexually Transmitted Disease (*The patient 12+ must authorize release)*

☐ Pregnancy (*The patient 12+ must authorize release)*

☐ Other: _____

ADDITIONAL: For Children Under Six Months of Age:
PKU or Neonatal Screening (Performed by the State of Illinois)
By Signing Below, I Authorize the Release of My Child/Children's PKU or Neonatal Screening to Wheaton Pediatrics, Ltd.

Birth Mother's Maiden Name: _____ (may be used by hospital)

X _____ (Please Sign) Neonatal Screening (PKU) Release

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.
I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.
I understand that the records authorized in this release will be utilized for the purposes of continuity of care for my child.
I understand that this authorization is valid until it expires, unless revoked before that.
I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office.

Please Send the Above Records To:

Wheaton Pediatrics, Ltd.
55 E. Loop Road, Suite 301
Wheaton, IL 60189
Fax: (630) 690-7335

Absent of written revocation, this Authorization for Release of Confidential Health Information will terminate on _____(Date).
(Otherwise will expire six months from date of signature)

_____ _____
Signature of Parent/Guardian **Date**

_____
Phone Number

_____ _____
Signature of Patient 12 years and up (May be required for release of items listed above) **Date**