Authorization Form
Release of Health Information

PEDIATRIC MEDICAL SERVICES, S.C.

SKOKIE HOSPITAL MEDICAL BUILDING
9669 Kenton, Suite 403
Skokie, IL 60076

ALISON GALANOPOULOS, M.D.
BERNARD HANKIN, M.D.
SUN-BUM KIM, M.D.

PHONE (847) 674-4730
FAX (847) 674-4732

I, _____, hereby authorize Dr. _____
(Patient or Guardian Name) (Doctor's Name)

_____
(Name and address of physician, Health Care Facility, etc.)

to release the medical record of _____
(Patient Name)

born ____/____/____, residing at _____
(Birth Date) (Street Address, City, State and Zip Code)

to the above mentioned doctors of Pediatric Medical Services. Records needed:

____ Vaccine Records and Growth Curve
____ Consult Letters
____ Radiology Reports
____ Progress Notes
____ Laboratory Results
or ____ Entire Medical Records

I understand that I have the right to inspect the information I have authorized to be released 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 information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

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 a case 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.

Signed:_____ Date:_____
(Patient, or Guardian if Patient is a minor)