Authorization Form
Request of Health Information
from
PEDIATRIC MEDICAL SERVICES, S.C.

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

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

I hereby request the release of the medical records of

_____, born ____/____/____. residing at
Patient Name (Birth Date)

_____ from Pediatric Medical Services
(Street Address, City, State and Zip Code)

to Dr. _____
(Doctor's Name)

of _____
(Name and address of Physician or Health Care Facility)

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)