AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patients name: ______________________________________

Patients Birthday: ____________________________________

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE TRANSFERRED

FROM:

Jercinovic Pediatrics Ltd.
807-Q W. Jefferson St.
Shorewood, IL 60431
Phone: 815.729.1144
Fax: 815.729-1157

TO:

Dr./Clinic ____

Address: ____

____

Phone: __________________________ **Fax:** ____________________

Signature: _________________________ **Date:** ___________________

Reason for Leaving: