 Thomas J. Herr, MD Elizabeth Richmiller, NP

1625 Avenue of the Cities

Moline, IL 61265

Fax (309) 797-3140

Phone (309) 797-5437



Haile Neptune, MD Scott Meskimen, NP

Anders J. Brodd, MD Kathleen Averill, NP

Molly Wiebel, NP

**CONSENT TO RELEASE INFORMATION**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INFORMATION TO BE RELEASED FROM: SEND REQUESTED INFORMATION TO:**

**Name/Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_ Name/Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: ­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City/State/Zip: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_**

**CHECK INFORMATION NEEDED:**

|  |  |  |  |
| --- | --- | --- | --- |
| * Immunizations | * Lab Reports | * Progress Reports | |
| * Consults/Referrals | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |

**PLEASE LIST ANY INFORMATION NOT TO BE RELEASED:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**THIS INFORMATION IS REQUIRED FOR:**

* Transfer of Care REASON:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Personal Copy
* Consultation/Referral

**HOW WOULD YOU LIKE TO RECEIVE YOUR RECORDS:**

|  |  |
| --- | --- |
| * Pick-up in clinic | * Mail to individual/agency listed |

**I give permission to release my information I’ve selected on this form to the individual(s) or agency(s) I’ve named and only for the purpose that I’ve checked. I have the right to view my medical records. Copies of my records may be obtained with reasonable notice with my written authorization. I understand that Pediatric Group Associates has up to 30 days to release the information requested. I understand that if I am transferring care Pediatric Group will continue to see me for 30 days after my information is released.**

**PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE OF REPRESENTATIVE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RELATIONSHIP TO INDIVIDUAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**