Authorization To Release Medical Information

Patients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_/\_\_\_\_\_\_\_\_

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

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

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Release To:  **CATCH A STAR LEARNING CENTER**

**424 WEST PIPER STREET**

**MACOMB, IL 61455**

**Phone: 309-833-2741 Fax: 309-837-9228**

Email: [ctchastr@macomb.com](mailto:ctchastr@macomb.com) Website: [www.catchastarlearningcenter.com](http://www.catchastarlearningcenter.com)

Release From (check one):

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| **Bushnell Family Practice** | **HSHS Medical Group** | **McDonough Medical Group** | **Medical Group of Macomb** |
| Dr John Arnold, MD | Gretchen Fawcett, PA-C | Dr Liberty Balbort, MD | Dr Mary Kathleen Lockard, MD |
| Carrie Helle, APN | 130 N Broadway St |  | Dr David Miller, DO |
| 155 W Hail St | Table Grove, IL 61482 | 505 E Grant, Suite 202 | 505 E Grant, Suite 103 |
| Bushnell, IL 61422 | 309-758-5070 phone | Macomb, IL 61455 | Macomb, IL 61455 |
| 309-772-9444 phone | 309-758-5007 fax | 309-833-1729 phone | 309-833-3536 phone |
| 309-772-9446 fax |  | 309-836-1779 fax | 309-836-5729 fax |
|  |  |   **Other** | |
| **Springfield Clinic of Macomb** |  | Dr: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Dr Curt Farr, MD |  |  | |
| Dr Charles O'Neill, MD |  | Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Dr Michelle Reeves, MD |  |  | |
| Dr Chris Stortzum, MD |  | City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Dr Amy Waschull, MD |  |  | |
| 505 E Grant, Suite 110 |  | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Macomb, IL 61455 |  |  | |
| 309-833-1733 phone |  | Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 309-836-2369 fax |  |  | |

Information to be released and SIGNED BY PHYSICIAN on required DCFS STATE OF IL CERTIFICATE OF CHILD HEALTH EXAMINATION FORM:

* PHYSICAL EXAM based on appointment date of \_\_\_/ \_\_\_/ \_\_\_\_\_
* IMMUNIZATIONS or ALTERNATIVE PROOF OF IMMUNITY
* TB TESTING and RESULTS
* LEAD TESTING and RESULTS
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*My refusal to consent to the release of the above-mentioned information will prevent the disclosure of the information. I have the right to revoke this authorization at any time by writing the Medical Record Department of the above stated Physician.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT SIGNATURE OR LEGAL REPRESENTATIVE DATE

4/28/2017