

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 Website: www.catchstarlearningcenter.com

Release From (check one):

<input type="checkbox"/> Bushnell Family Practice Dr John Arnold, MD Carrie Helle, APN 155 W Hail St Bushnell, IL 61422 309-772-9444 phone 309-772-9446 fax	<input type="checkbox"/> HSHS Medical Group Gretchen Fawcett, PA-C 130 N Broadway St Table Grove, IL 61482 309-758-5007 fax	<input type="checkbox"/> McDonough Medical Group Dr Liberty Balbort, MD Julie Bartlow, NNP-BC 505 E Grant, Suite 202 Macomb, IL 61455 309-833-1729 phone 309-836-1779 fax	<input type="checkbox"/> Medical Group of Macomb Dr Mary Kathleen Lockard, MD Dr David Miller, DO 505 E Grant, Suite 103 Macomb, IL 61455 309-833-3536 phone 309-836-5729 fax
<input type="checkbox"/> Memorial Medical Clinic Khristy Wisslead, APN-FNP 110 Market St, PO Box 59 Colchester, IL 62326 309-776-3301 phone 309-776-3370 fax	<input type="checkbox"/> MCUSD #185 MacArthur School 309-833-4273 phone <u>309-833-5651 fax</u> Lincoln School 309-833-6340 phone <u>309-837-7802 fax</u> Edison School 309-833-6330 phone 309-837-9992 fax	<input type="checkbox"/> Springfield Clinic of Macomb Dr Curt Farr, MD Dr Charles O'Neill, MD Dr Michelle Reeves, MD Dr Chris Stortzum, MD Dr Amy Waschull, MD 505 E Grant, Suite 110 Macomb, IL 61455 309-833-1733 phone 309-836-1450 fax	<input type="checkbox"/> Other Dr: _____ Address: _____ _____ Phone: _____ 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
- ALLERGY 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

