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.catchastarlearningcenter.com

Release From (check one):

☐	☐	☐	☐
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	**HSHS Medical Group** Gretchen Fawcett, PA-C 130 N Broadway St Table Grove, IL 61482 309-758-5070 phone 309-758-5007 fax	**McDonough Medical Group** Dr Liberty Balbort, MD 505 E Grant, Suite 202 Macomb, IL 61455 309-833-1729 phone 309-836-1779 fax	**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
☐	☐	☐ **Other**	
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 309-836-2369 fax		Dr: _____ Address: _____ City, State, Zip: _____ 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
- ☐ _____

*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