FAX COVER SHEET

STREETERVILLE PEDIATRICS
233 EAST ERIE STREET SUITE 304
CHICAGO, ILLINOIS 60611
www.streetervillepediatrics.com
tel 312/280-1480
fax 312/280-1485

Donald K. Brown, MD
Kathleen K. Starr, MD
Katie M. McCabe, MD

TO: _____ FAX #: _____

FROM: _____ DATE: _____ #Pages (including cover) _____

MEDICAL RECORDS RELEASE REQUEST

I hereby authorize and request to Dr. _____ to release all medical records and test results of my child (ren) to:

Streeterville Pediatrics
Donald Brown MD/Kathleen K Starr MD/Katie M. McCabe, MD
233 East Erie Street Suite 304, Chicago, Illinois 60611
tel 312/280-1480 fax: 312/280-1485

Patient Name(s) / DOB _____

_____

Address: _____

Signature of Patient / Guardian: _____

Relationship to Patient: _____ Date of Request: _____

RETURN FAX: 312/280-1485