

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: _____

NOTE: The information in this fax may be privileged and confidential and protected from disclosure. If the reader of this fax is not the intended recipient, you are hereby notified that any reading, dissemination, distribution, copying, or other use of this fax is strictly prohibited. If you have received this fax in error, please notify the sender immediately by telephone at 312/280-1480 and destroy this fax. Thank you.

RETURN FAX: 312/280-1485