MP Pediatrics

Dr. Jennifer Perez, MD, FAAP, DABOM
1400 W 47th St Unit 1
LaGrange, IL 60525
Phone: (773) 284-6270 Fax: (773) 284-6290

Patient Name _____ Date of Birth _____

(nombre del paciente) (fecha de Nacimiento)

Address: _____

(direccion complete)

I hereby authorize the release of the following protected health information for the above-named individual: (Por la presente, yo autorizo la entrega de la siguiente infomacion contenida al indivuduo nombrado)

From (de) To: (para)

Dr. Jennifer A. Perez M.D.

Send to (mandar a) Request from (pedido por)

Dr. Name/ Facility _____

Address: _____

City: _____

Phone & Fax number _____

( ) Progress Notes	( ) History and physical Exam	( ) Laboratory Results
( ) Consultation	( ) X-ray report	( ) MRI report
( ) Medication Record	( ) Operative Report	( ) Immunization Record
( ) Discharge Summary	( ) Emergency Room	( ) Entire Record

( ) Other: _____

Include from the date of: _____ To: _____

For the purpose of:

( ) continue medical care	( ) Legal counsel	( ) Insurance claim
( ) School/ Daycare	( ) Changing Doctor	( ) Other

No limitation will be placed on this release of release of information related to the testing and/ or diagnosis and /or treatment of mental health, alcohol and/or substance use/abuse HIV/AIDS, sexually transmitted disease or related condition. (Esta entrega de informacion podria contener informacion relacionada a los examines, diagnostic y/o tratamiento de salud mental, alcohol y/o uso/abuso de sustancia, HIV/AIDS, enfermedades transmitidas sexualemente o condiciones relacionadas)

This authorization will be expire one (1) year from date of signature,unless revoked in writing, I hereby release Dr. Cesar E. Menendez M.D and Dr. Jennifer A. Perez M.D. from any liability by releasing this information. (Esta authorizacion se vence en un (1) ano despues de la fecha firmada a menos a que sea revocada antes por escrito, por la presente dejo libre de cargos al Dr. Cesar E. Menendez M.D y Dr. Jennifer A. Perez M.S de cualquier obsignacion por entrega de esta information.)

Signature (Firma) _____ DATE: _____Relatinship to patiend (relacion al paciente : _____