



Moshe Singer M.D.
773-831-7337
Oncall-peds.com

Authorization for Release of Medical Information

Patient Name: _____

DOB: ____/____/____

I, _____ hereby authorize the release of

medical information **TO:**

PediatricCare LLC/ Samuel Moshe Singer, MD
2934 W Sherwin Ave, Chicago, IL, 60645
Phone: 773-831-7337 Fax: 216-249-9038
Email: Singer@oncall-peds.com Web: <https://www.oncall-peds.com>

FROM:

Doctor/Clinic/Hospital: _____

Address: _____

Telephone: _____ Fax : _____

Please release the following:

All health information (including growth charts and vaccination records)

History/Physical Exam Diagnostic Test Reports

Progress Notes Radiology/Images

Discharge Summary Lab Results

Consultation Reports Pathology Reports

Other (specify): _____

Purpose of disclosure:

Treatment/ Continuing medical care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature: _____

Date: ____/____/____

Print Name: _____

Relationship to Patient: _____