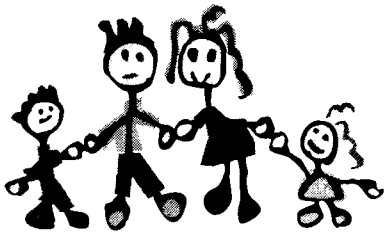


T.L.C. Pediatrics, Ltd.

4600 Memorial Drive, Suite 280 • Belleville, IL 62226
Phone: 618-257-2800 • Exchange: 618-398-9730
www.tlcpediatricsltd.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Print Patient Full Name _____ Date of Birth _____

Street Address _____ Social Security Number _____

City/State/Zip _____ Home Phone Number _____

At the request of the individual, I_____ _, do hereby authorize

TLC PEDIATRICS, LTD
4600 MEMORIAL DRIVE, STE 280
BELLEVILLE, IL 62226 fax#(618) 257-9802

To Release:

_Discharge Summary	_Pathology Report	_Emergency Report
_History & Physical	_Laboratory Reports	_Shot Records
_Progress Notes	_Radiology Reports	_ Operative Notes
_ECG/EEG/Cardiac Gath	_ Physical Form	_Other _____ _

_I do _I do Not Authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: _____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City/State/Zip

PURPOSE OF DISCLOSURE:

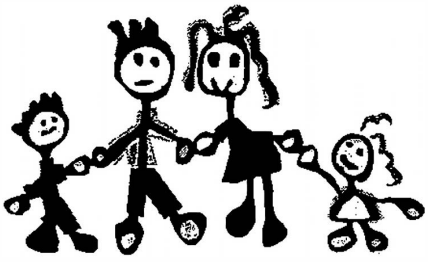
_Referral to specialist	_Insurance	_Workers Comp	_Change of Doctor/Provider
_Legal Investigation	_Personal	_Continuing Care	_Disability Determination

_Other (Please Specify)_____ _
Please provide the best telephone number in the event we need to contact you (home, work or cell)_____ _

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but it will not affect any information prior to written notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of person or facility receiving it and then would no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of individual or guardian or personal representative of patients estate _____ Date _____

*****ACCORDING TO HIPAA AND STATE OF ILLINOIS GUIDELINES A MEDICAL RECORD FEE MAY APPLY*****



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DESIGNATION OF AUTHORIZED ADULT REPRESENTATIVE(S)
And emergency contacts (other than parents)

In my absence, I hereby give permission to the following person(s) to bring my child or children to TLC Pediatrics LTD to seek medical care.

PATIENT NAME _____ _

DATE OF BIRTH _____ _

Name (First and Last)	Phone	Relationship to child

I understand that care will be provided by the physicians and the practice staff, including the administration of any medications and/or vaccinations deemed necessary by the physicians at the time. I will make every effort to call TLC Pediatrics LTD office with any questions I have about my child's care following any visit where I am not present. I understand that until I provide written notice to the practice of any changes to the designation of authorized adult representatives, TLC Pediatrics LTD may rely on the consent provided herein.

Signature of parent/ guardian or assigned representative **Relationship to child**

Print Name **Date**