

**TOWN AND COUNTRY PEDIATRICS**  
**MEDICAL RECORDS REQUEST**

DATE: \_\_\_\_\_

**I hereby authorize Town and Country Pediatrics to copy the medical record of the patient (s) listed below:**

Records may be reproduced in whole or in part as needed.

**Child's name**

**Date of Birth**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reason(s) for transfer: Check all that apply.

Insurance \_\_\_\_\_ New Doctor \_\_\_\_\_ Specialist \_\_\_\_\_ Moving \_\_\_\_\_ Dissatisfied \_\_\_\_\_

Other \_\_\_\_\_

**Choose one of these options:**

1. I will pick up the records when they are completed. Please call me.

Daytime phone number \_\_\_\_\_ Evening phone Number \_\_\_\_\_

2. Send the copied records to: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent/Guardian Name: (print) \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_

Fee: \$25; 2<sup>nd</sup> time to copy: \$35 Same day \$50- Please allow 7 working days.

Please drop this off at your child's Town and Country Pediatrics location or fax to:

**Halsted** office: 312-981-6312 or email **tchalsted@covad.net**

**Glenview** office: 847-998-8807 or email **tcglenview@covad.net**

**Lincoln** office: 773-478-4916 or email **tclincoln@covad.net**