Downers Grove Pediatrics

Dedicated to the Health of Your Child

PATIENT RECORD REQUEST FROM ANOTHER OFFICE

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

PHONE NO: _____

I _____, PARENT/LEGAL GUARDIAN OF THE ABOVE-CAPTIONED PATIENT, HEREBY AUTHORIZE THAT THE FOLLOWING MEDICAL RECORDS BE TRANSFERRED:

- ☐ COMPLETE CHART
- ☐ PROGRESS NOTES
- ☐ VACCINE RECORDS
- ☐ LABORATORY RESULTS

FROM: Person/Institution_____

Address: _____

City:_____, State:_____, Zip:_____

Phone: _____ FAX:_____

TO: DOWNERS GROVE PEDIATRICS, LTD.

☐ 6840 S. Main Street, Suite 201
Downers Grove, IL 60516
Office: 630-852-4551
Fax: 630-852-0131

☐ 404C W. Boughton Road
Bolingbrook, IL 60440
Office: 630-759-9230
Fax: 630-759-9102

_____ DATE:_____

Signature of Parent/Legal Guardian