Parkside Pediatrics, S.C.
1875 Dempster Street
Suite 650
Park Ridge, IL 60068
847/823-8000

Date: _____

I give my consent for Parkside Pediatrics, including Dr. Roemisch and Dr. Kolezeva, to discuss any medical issues that pertain to me with the following indicated individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

There are no restrictions on what medical information may be reviewed, unless indicated below:

_____

_____

This release will continue in effect until I revoke it in writing, which I can do at any time.

_____ _____

Signature Printed Name