



Patient Information			
Patient's Legal Name <i>(First, Middle, Last)</i>		Date of Birth	Pediatrician/Provider
Patient's Mailing Address		City	State      Zip
Patient's Email for Portal Access <i>(required at age 18)</i>			Patient's Phone Number
Preferred Method of Contact for Notifications <input type="checkbox"/> Phone Call <input type="checkbox"/> Text <input type="checkbox"/> Email			<i>You may opt out of notifications at any time by contacting the practice at 309-662-0504, opt 3.</i>

Authorization to Release Information			
By signing below, I hereby authorize the persons listed below access to any and all of my protected health information.			
Name of Other Adult Caregiver		Caregiver Relation to Patient	Caregiver Phone Number
Email Address		Enable Portal Access? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Other Adult Caregiver		Caregiver Relation to Patient	Caregiver Phone Number
Email Address		Enable Portal Access? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Other Adult Caregiver		Caregiver Relation to Patient	Caregiver Phone Number
Email Address		Enable Portal Access? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Other Adult Caregiver		Caregiver Relation to Patient	Caregiver Phone Number
Email Address		Enable Portal Access? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Expiration of Authorization	
This consent will expire on the date entered or upon written notice from the patient	Expiration Date
<b>Signature of Patient</b>	Date