

# **RELEASE OF MEDICAL INFORMATION:**

Patient: Complete the upper portion of this form, and forward to your physician who will in turn complete the lower portion. Your physician should then forward this form to the PKU Organization of Illinois.(You may wish to assist your physician by including a pre-addressed envelope).

I, \_\_\_\_\_, do hereby request and authorize  
(Name of Patient)

\_\_\_\_\_ to release medical information indicating the  
(Physician's Name/Institution)

Diagnosis of PKU / Allied Disorder concerning \_\_\_\_\_  
(Name of Patient)

to the PKU Organization of Illinois Andrew Craig Memorial Scholarship Program.

(Patient Signature) \_\_\_\_\_

(Guardian Signature) \_\_\_\_\_  
(Required if Patient if a Minor)

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I, \_\_\_\_\_ do hereby attest that \_\_\_\_\_  
(Physician's Name/Institution) (Patient Name)

has been diagnosed with PKU or an Allied Disorder.

\_\_\_\_\_  
(Physician/Institution)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Physician Signature)

\_\_\_\_\_  
(Date)