PKU ORGANIZATION OF ILLINOIS
& ALLIED DISORDERS

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Palatine, IL 60078

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RELEASE OF MEDICAL INFORMATION

Applicant/Patient: Complete the upper portion of this form, and forward to your physician who should complete the lower portion and send back to the applicant/patient.

I, _____ , do hereby request and authorize my physician,
(Name of Patient)

_____ , to release medical information indicating the diagnosis of PKU/
(Physician's Name & Institution)

Allied Disorder concerning _____ to the **PKU Organization of Illinois**
(Name of Patient)

Andrew Craig Memorial Scholarship Program.

Patient Signature: _____

Guardian Signature (required if patient is a minor): _____

I, _____ , do hereby attest that _____
(Physician's Name & Institution) (Patient Name)

has been diagnosed with PKU or an Allied Disorder.

_____
(Physician's Name & Institution)

_____
(Address)

_____ _____
(Physician Signature) (Date)